# 36

Synthèse
critique

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# Privatization: Adopt or Adapt?

Lee Soderstrom

COMMISSION D'ENQUÊTE
SUR LES SERVICES DE SANTÉ
ET LES SERVICES SOCIAUX

Québec

**36**

**Synthèse critique**

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# PRIVATIZATION: ADOPT OR ADAPT?

Un rapport pour
la Commission d'enquête sur les services de santé
et les services sociaux

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# TABLE OF CONTENTS

Chapter

I. Introduction ........ I-1

II. Privatization: The Possibilities ........ II- 1
Definition of Privatization ........ II- 1
Some Possible Forms of Privatization ........ II- 5
    Financing of Health Services ........ II- 5
    Provision of Health Services ........ II- 9
    Management of the Health System ........ II-14

III. Privatization: What Are We Trying to Accomplish? ........ III- 1
Equity and Efficiency ........ III- 1
    The Meaning of Efficiency ........ III- 3
    Equity ........ III- 6
Current Problems ........ III- 7
The Role of the State in the Coming Years ........ III-10
    The Role of Privatization ........ III-17

IV. User Charges ........ IV- 1
Rationale for Deterrent Charges ........ IV- 1
    Three Concerns ........ IV- 2
Deterrent Charges: The Empirical Evidence ........ IV- 5
    The Saskatchewan Experience ........ IV- 6
    The RAND Study ........ IV- 8
    RAND: Expenditure and Utilization Effects ........ IV- 9
    RAND: Health Effects ........ IV-11
    RAND: Commentary ........ IV-14
Taxation of Health Benefits ........ IV-19
    Equivalent to a Deterrent Charge ........ IV-19
    Simulated Effects ........ IV-21
Extrabilling ........ IV-23
    Consequences ........ IV-23
Implications of Canada Health Act ........ IV-26
Conclusion ........ IV-27

V. Other Forms of Private Financing ........ V- 1
Private Funding for Investments ........ V- 1
  The Issues ........ V- 1
  Financing Methods and the Availability of Services ........ V- 3
  Public Financing of Private Financing ........ V- 4
  Need for Public Management ........ V- 6
  Conclusion ........ V-10
The Sale of "Extra" Services ........ V-11
  Use of the "Profits" ........ V-12
  Some Potential Problems ........ V-13
  Conclusion ........ V-15

VI. Investor-Owned Hospitals ........ VI- 1
Ownership and Efficiency ........ VI- 1
  Organizational Differences ........ VI- 1
  The Cost of Services ........ VI- 3
  The Mix of Services ........ VI- 6
Empirical Evidence ........ VI-12
  Cost and Revenue Effects ........ VI-12
  Patient Selection and Quality ........ VI-16
  Committee on Implications of For-Profit Enterprise ........ VI-18
Role of Investor-Owned Hospitals in Quebec ........ VI-19
  Relevance of the American Evidence ........ VI-20
  Different Incentives vs Different Management ........ VI-21
  Consequences for Industrial Relations ........ VI-24
Appendix: Ownership and Performance of American Nursing Homes ........ VI-25
  Reasons for Cost and Quality Differences ........ VI-25

VII. Subcontracting Management Functions ........ VII- 1
Consequences of Outside Management ........ VII- 2
Empirical Evidence ........ VII- 4
  Effects on Hospital Costs ........ VII- 5
Outside Management for Quebec Hospitals ........ VII- 7
  The Management Contract ........ VII- 9
  Impact on Public Management ........ VII-10
  Final Observations ........ VII-12

VIII. Family Care

VIII. Family Care .......... VIII- 1
Evaluation Criteria .......... VIII- 2
Parent Care .......... VIII- 3
  Reduced Treatment Costs .......... VIII- 4
  Comments .......... VIII- 6
Day Surgery .......... VIII- 7
  Health Outcomes .......... VIII- 8
  Reduced Treatment Costs .......... VIII- 9
  Comments .......... VIII-10
Home Care .......... VIII-11
  Consequences of Home Care .......... VIII-12
  Reasons for Negative Evaluations .......... VIII-14
  Lack of Evidence on "Private Consequences" .......... VIII-16
  Financing of Home Care Services .......... VIII-17
Concluding Comments .......... VIII-18

IX. HMOs and Price-Competition .......... IX- 1
Price-Competition .......... IX- 2
The Key Elements .......... IX- 3
  The Competing Plans .......... IX- 3
  The Annual Per Capita Grant .......... IX- 5
  The Membership Fee .......... IX- 6
  The Enrollment Decision .......... IX- 8
Dynamics of Price-Competition .......... IX- 9
  A Simple Scenario .......... IX- 9
  Some Complications .......... IX-13
  Some More Complications .......... IX-17
  Summary: Effects on Health Costs .......... IX-19
The Role of the State .......... IX-21
  Determination of the Per Capita Grant .......... IX-21
  Consumer Protection .......... IX-24
  Shaping the Environment .......... IX-25
  Price-Competition and Privatization .......... IX-27
Consequences for Users of the System .......... IX-27
  Equity in Access .......... IX-28
  Bureaucracy .......... IX-31
  Consumers' Ability to Evaluate Competing Plans .......... IX-33

Price-Competition: Concluding Observations .......... IX-35
    Negative Side-Effects .......... IX-35
    Impact of Health Costs .......... IX-35
    Role of Price-Competition .......... IX-36
HMOs: Another Look .......... IX-38
    Private HMOs .......... IX-41
Appendix: Some Simulated Effects of Price-Competition .......... IX-42

X. Privatization: Some Reflections .......... X- 1
Summary of Evaluations .......... X- 1
    User Charges .......... X- 1
    Sale of Extra Services .......... X- 1
    Increased Private Funding of Capital Projects .......... X- 2
    Investor-Ownership of Acute Care Hospitals .......... X- 3
    Subcontracting Management Functions .......... X- 4
    Family Care .......... X- 4
    Price-Competition .......... X- 5
    HMOs .......... X- 5
    Other Forms of Privatization .......... X- 6
Some Observations .......... X- 7
    Need for Scientifically Valid Evaluations .......... X- 7
    Lack of Information about "Private Consequences" .......... X- 9
    Impact of Privatization on Industrial Relations .......... X-12
Relevance of Privatization .......... X-13
    Continuing Importance of the State .......... X-13
    Technology Assessment .......... X-15
Adaptation .......... X-18
    Structure of Management .......... X-19
    Management Practices .......... X-22
Final Comments .......... X-26

R. References .......... R- 1

# Chapter I
# INTRODUCTION

"The grass always seems greener on the other side of the fence."
--anonymous cow

Currently there is interest in a variety of proposals aimed at reducing the government's role in Quebec's health system. This is not surprising in a society where the State as an active force has become the subject of much controversy, stemming both from experiences with government involvement and from ideology. In recent years as well the idea of privatizing various government activities has become high fashion.

However, one may feel strongly that extensive government involvement in our health system is desirable, but at the same time find that some forms of privatization nicely complement the activities of the State[1]. The "privatization" of aspects of Quebec's health system could take many quite different forms. Some may be desirable, others not. Each should be considered on its own merits.

A variety of possible ways to privatize various aspects of our health system are evaluated here. This is a search for evidence--theoretical and empirical--that one or more of them might enhance social welfare. Two questions underlie the evaluation of each scheme. First, is it supposed to offer a solution for one of the actual problems plaguing our system? If our problems were related to hospital laundry services, a scheme to improve dietary services would not be very relevant.

Second, whatever problem the scheme is aimed at, what would be the scheme's consequences? Would it resolve the problem? Would it have any negative side-effects? Most forms of privatization ultimately involve shifting some responsibility from the State to private individuals. It is imperative, then, that reasonable evidence relating to the consequences for patients and their families be available before decisions are made about privatizing something.

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[1] The converse is true, as well.

This is not the first survey of various privatization proposals. In Canada, L'Association des hôpitaux du Canada (1985) and Stoddart and Labelle (1985) have both prepared commendable surveys of some proposals. In the United States, the Institute of Medicine's Committe on Implications of For-Profit Enterprise in Health Care (Institute of Medicine, 1986) has just produced a massive evaluation of investor-owned hospitals. The analysis presented here certainly draws on these three evaluations. But it also goes beyond them, covering somewhat different literature and a larger range of privatization proposals. Moreover, the focus of this evaluation is on Quebec. However, the three earlier groups' conclusions about particular forms of privatization are very similar to those that emerge here, if concensus is any comfort.

A variety of possible forms of privatization are described in the next chapter. Indeed, the list is lengthy; many long-discussed reforms involve at least some degree of privatization. Then, in Chapter III it is argued that these schemes should be evaluated by assessing their effects on the efficiency and equity of Quebec's health system. In Chapters IV to IX the various privatization proposals are evaluated. These evaluations relate largely to the impact of these schemes on the problems for which they are prescribed.

In Chapter X the results which emerged in the preceding six chapters are summarized briefly, and then attention shifts to the impact the various proposals would have on major problems now plaguing our health system. The thrust of the analysis is that few of the proposals seem to warrant adoption. But, it is argued at the end of Chapter X, they do contain some valuable ideas worth adapting to Quebec's situation.

## Chapter II
# PRIVATIZATION: THE POSSIBILITIES

The specific forms of privatization to be evaluated are described in this chapter. There are more possibilities, however, than can be reviewed in this analysis. This becomes clear when the concept "privatization" is defined, and the Quebec government's current extensive involvement in our health system is summarized. Thus, only the forms which are relevant for Quebec's health system and which are currently being discussed are evaluated in subsequent chapters.

### Definition of Privatization

There is no single, widely accepted definition of this frequently used concept. Some writers have only scribbled a definition in passing. Others, whether interested in the privatization of health services or some other aspect of government activity, have focused on particular reforms, and have not bothered to define the concept. Moreover, the specific forms of privatization that have been considered vary from writer to writer[1].

The definition offered by Weldon(1984) is as reasonable as any available definition, and it is also consistent with most usages of the concept that are found in the literature. He defined privatization as "...transferring authority, decision and power from the State to private organizations and especially (but not exclusively) to the apparatus of the marketplace." Three aspects of this definiton are particularly noteworthy. First, it refers to a wide range of government functions, implying that privatization can involve more than just a shift of ownership from the government sector to the private sector. Thus, shifting responsibility for providing a service from a government agency to a private individual is a form of privatization. Second, although it refers to a transfer from the State to private organizations, this definition does not imply that the transfer must always be to the market place. Thus, requiring users of a government service to pay something is a form of privatization.

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[1] For example, Stoddart and Labelle(1985) consider 5 possiblities: "i) increased use of private-for-profit management of hospitals; ii) increased private funding of institutions, through philanthropy, commercial activites or contracts with other corporations, for purposes of capital replacement or facility/program expansion; iii) increased private funding of physician services through extra-billing; iv) increased private funding of hospital services through user charges; and v) the contracting out of certain elements of the administration of provincial health insurance plans." The list considered by l'Association des hôpitaux du Canada(1985) with respect to the privatization of hospital services is a little different: i) les frais modérateurs; ii) les écarts de prix des chambres; iii) le programme BOND (de l'Ontario); iv) la philanthropie et bénévolat; v) les contrats de gestion (services de soutien); vi) contrats de gestion (hôpital entier); vii) l'investissement de capitaux privés; viii) la propriété privée; et ix) l'introduction des groupes de diagnostic homogénes.

Finally, this definition does not take into account a peculiar characteristic of the health sector: most organizations that provide personal health services are neither government owned, nor private, for-profit organizations. This raises several questions: does privatization include a transfer of some function from the State to this nonprofit sector? does it include a transfer from the nonprofit sector to the (traditional) private sector? It seems reasonable to answer "yes" to both questions. These answers, however, are not crucial for the analysis that follows, so only a short discussion of this issue is warranted.

Regarding both types of transfers as forms of privatization is consistent both with the popular usage of the term and with the two, closely related ideas which underlie privatization as indicated in Weldon's definition. One idea is the desirability of reducing the role of the State by shifting some functions from its immediate domain. Proponents of privatization argue that if certain activities of the State were shifted to certain other organizations, which have different motives and constraints, society's welfare would be enhanced. Thus, it is reasonable that "privatization" should include the shifting of some functions away from the State--whether the shift be to the nonprofit sector or profit sector[2].

The second idea is the desirability of placing more reliance on the private sector. A central element in privatization proposals is that they involve shifting certain functions to private actors, be they individuals or private firms. For example, a crown corporation is privatized by selling it to a private corporation. Thus, it is reasonable that "privatization" should also include the shift of a health related function into the private sector--whether the shift be from the government sector or from the nonprofit sector.

Government is involved in the health system in three ways: it is a very important source of financing for the system; it is extensively involved in the management of the system; and it is involved in the provision of some health services. The nonprofit sector, however, is much more involved in the provision of health services. Consequently, the privatization of the health system includes any shift away from the State of financial or "system" management functions, or any shift away from either the State or the nonprofit sector of some aspect of their current responsibilities to supply health services.

As already indicated, "privatization" includes a large variety of possible reforms. Obviously, only a few can be discussed here. A rather pragmatic approach has been used to select those to be evaluated. First, only those proposals which seem reasonably consistent with social values in Quebec have been considered. For example, one possible reform would be to replace much government financing of physician and hospital services with private insurance. This would be a shift towards the financing mechanism that is found in the United States. But there is little interest in such a reform in Quebec; the idea of public financing of a comprehensive set of health services for all Quebecers seems firmly rooted here. The American system has been viewed for a long time as both inefficient and inequitable by most observers of Quebec's health system. Even the Americans are now trying to move away from the system they have had for the past 20 years.

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[2] Note that in the education sector, there is also a non-profit sector, the "private schools". As the name implies, this the non-profit sector is not viewed as a mere extension of the government sector.

Secondly, the focus is on proposals that observers of our system have been discussing. For example, the proposals analyzed include those made by le Groupe de travail sur la révision des fonctions et des organisations gouvernementals (Québec,1986b)--hereafter, le Groupe de travail. It has just made a series of recommendations for privatizing various aspects of the system. On the other hand, many of the administrative functions now performed by the Régie de l'assurance-maladie du Québec (RAMQ) could be privatized. But no one seems very interested in doing that, so this is not considered here.

Finally, largely because of time constraints, the focus will be primarily on proposals relating to the privatization of physician and acute care hospital services. Although other health services are not at center stage, a few words will be said about some of them. On the other hand, prevention is a form of privatization, too. In order to reduce the need for publicly financed hospital and physician services, individuals are urged to take more responsibility for their own personal health, by stopping smoking, reducing their drinking, doing more physical activity, etc. But prevention involves quite a different set of issues from those related to the privatization of physician and hospital services, so this form of privatization is not discussed here.

## SOME POSSIBLE FORMS OF PRIVATIZATION

Public involvement in the health system takes three general forms. For each one, the nature of the current involvement is briefly reviewed and some possibilities for privatization described.

### Financing of Health Services

Government currently is certainly a major source of financing for the health system. As indicated in Table I, private expenditures accounted for only 21 percent of total health spending in Quebec in 1985--government accounted for the remaining 79 percent. Private expenditures include bills which people paid directly from their own pockets or which were covered by supplementary health insurance. Private spending was slightly more important elsewhere in Canada, largely because of more private spending on dental services and on drugs and appliances[3].

The importance of private spending has been slowly increasing in Quebec, though not elsewhere in Canada. Between 1975 and 1977 private spending averaged 17.9 percent of total expenditures in Quebec, and between

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[3] This is because much more was spent per person Canada-wide on dental services as well as on drugs and appliances than in Quebec, as indicated in Table I.

## Table I
## Health Expenditures in Quebec, 1985[a]

| Type of Expenditure | Quebec, Total Expenditures, 1985 | Private Expenditures as a Percentage of Total Expenditures, 1985 | | Total Expenditures per Person, 1985 | | Total Expenditures as a Percentage of Provincial Gross Domestic Product, 1984 | |
|---|---|---|---|---|---|---|---|
| | | Quebec | Canada | Quebec | Canada | Quebec | Canada |
| Personal Health Care Expenses | $8,482.0 | 20.4% | 24.5% | $1287.88 | $1353.13 | 8.25% | 7.34% |
| Institutional and Related Services[b] | 5,581.8 | 10.6 | 12.0 | 847.53 | 805.63 | 5.52 | 4.43 |
| Professional Services | 1,830.4 | 20.7 | 27.2 | 277.93 | 352.78 | 1.75 | 1.90 |
| Physicians | 1,343.6 | 4.0 | 5.7 | 204.01 | 246.23 | 1.29 | 1.32 |
| Dentists | 388.0 | 68.5 | 86.5 | 58.92 | 85.81 | .37 | .46 |
| Other Professionals[c] | 98.8 | 59.6 | 38.0 | 15.00 | 20.74 | .09 | .12 |
| Drugs and Appliances[d] | 1,069.8 | 73.9 | 76.8 | 162.43 | 194.71 | .98 | 1.02 |
| Other Health Expenses | 1,218.9 | 26.0 | 23.9 | 185.08 | 190.13 | 1.10 | 1.06 |
| Capital Expenditure | 432.5 | 44.2 | 26.8 | 65.66 | 69.25 | .36 | .41 |
| Other Expenses[e] | 786.4 | 16.0 | 22.2 | 119.42 | 120.88 | .74 | .65 |
| Total Health Expenses | 9,700.9 | 21.1 | 24.4 | 1472.97 | 1543.26 | 9.35 | 8.40 |

Source: Health Information Division, Health and Welfare Canada, unpublished data.

Notes:

a. The data for 1985 are preliminary, but the patterns with respect to the importance of private spending are consistent with those observed in years for which final data are available. Because of estimation problems the sum of the private expenditures for individual items exceeds the reported total by $33 million for Quebec and $284 for Canada.

b. Includes hospitals, other institutions home care and ambulances.

c. Includes chiropractors, optometrists, podiatrists, osteopaths, private duty nurses and physiotherapists.

d. Includes prescribed and non-prescribed drugs, eyeglasses, hearing aids, other appliances and prostheses.

e. Includes prepayment administration, public health, health research and miscellaneous health costs.

1983 and 1985 it averaged 20.3 percent. At least in recent years the increase has stemed from more private spending for drugs and appliances and for investments in plant and equipment[4].

The extent of public financing varies among services because our public financing programs do not provide equal coverage for all services. Private spending accounted for only 10 percent of the expenditures of hospital and other institutional services and 4 percent of the expenditures for physician services because our public financing programs for these services are universal and comprehensive. Users of physician and acute care hospital services pay nothing out-of-pocket[5].

On the other hand, our public financing programs for other personal services are much more limited in scope, so private spending accounts for a much larger share of the expenditures for these services. For example, public financing of dental services is limited to certain services for children and social assistance recipients. This explains why private spending accounts for 69 percent of spending for dental services.

Thus, not surprisingly, one frequently advocated way to privatize finance would be to introduce user charges for physician and acute care hospital services. This would involve patients paying something for services actually received, thereby reducing the money that the government would spend for these services. User charges could take several forms, depending on who determined the charges. Deterrent charges would involve the government itself stipulating that users pay a prescribed amount. For example, it could require that people pay $2 for a physician office visit and $3 per day of hospitalization. Alternatively, extrabilling would involve physicians and hospitals setting the amount of the charge themselves. When physicians extrabilled in Alberta, for example, the amount varied among physicians, patients and types of service (Plain, 1984).

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[4] Between 1983 and 1985 (preliminary data) private spending on drugs and appliances jumped from 7.4 to 8.1 percent of total costs, and for investments from 1.1 to 2.0 percent.

[5] There are some notable exceptions. First, people who receive services from one of the very few non-participating physicians must pay the full cost from their own pockets. Second, people who want a semi-private or private hospital room must pay a special charge, which is often covered by supplementary health insurance. Finally, the chronically ill who are in an acute care or chronic care hospital and people in a centre d'accueil do pay a user charge. For example, in 1986 people who were long term, chronic care patients in an acute care hospital, but who required no acute medical care services, paid $15.90 per day if they are in a ward, $21.41 if in a semi-private room, and $25.60 if in a private room.

The introduction of user charges is certainly not a new idea. The wisdom of introducing them has been the subject of re-occurring debate among health planners in Quebec and elsewhere. The intensity of the debate has increased in recent years, however. For example, in the Spring of 1981 the Ministers of Finance and Social Affairs, Messers Parizeau and Johnson, suggested that a $2 deterrent charges be instituted for physician office visits. Then, for several years prior to the passage of the Canada Health Act by the federal government in April 1984, there was debate in Quebec and other provinces about the wisdom of user charges, particularly extrabilling by physicians. Now, extrabilling has been eliminated and British Columbia is the only province with a deterrent charge for acute care hospital services[6]. A number of provinces have recently added charges for chronic care services, however.

User charges are analyzed in considerable detail in Chapter IV. When possible types of privatization are considered, they are usually one form mentioned. Le Groupe de travail has recommended the introduction of a tax-based deterrent charge scheme for all publicly financed health services.

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[6] It continues to levy a deterrent charge for acute care hospital services.

Other possibilities for privatizing finance also warrant some discussion. Greater use of private financing for new investments is one such possibility. Even now, private funding is an important source of finance for new investment projects here, as the data presented in Table II indicates. Between 1975 and 1985 private funding covered 41.7 percent of the cost of new investments in Quebec, a larger fraction than this source covered elsewhere in Canada.

This private funding could take a variety of forms. At present there are only two, private borrowing and philanthropy . Private borrowing typically involves a hospital obtaining a loan from a financial institution; it could also involve the hospital selling bonds to be redeemed later. In the future, private finance for new projects could be raised in several other ways, too. Hospitals could extrabill their patients, and then use the revenue to finance new projects. Or, if hospitals were investor-owned, new projects could be financed by the sale of equity (i.e. shares). The wisdom of private funding for new projects is discussed in Chapter V. The analysis of extrabilling is in Chapter IV and that of investor-owned hospitals in Chapter VI.

Another frequently mentioned way to privatize some hospital finance would involve hospitals raising more money for themselves through increased sales of "extra services". Hospitals (and their affiliated organizations) already provide a variety of auxilliary services, ranging from parking and food services for staff and visitors to gift shops. They also collect revenue from patients using semi-private and private rooms. In 1983 Quebec acute care hospitals reported net revenues of $6 million from the sale of auxilliary services and $24 million from charges for semi-

Table II

## New Investment in the Health System[a] Quebec, 1975-1985

| Year | Quebec Total Investment (million$) | Private Funding as Percent of Total Investment | | Total Investment as Percentage of Provincial GDP | | Total Investment per Person | |
|---|---|---|---|---|---|---|---|
| | | Quebec | Canada | Quebec | Canada | Quebec | Canada |
| 1975 | $173.5 | 33.1% | 39.3% | 0.44% | 0.36% | $28.06 | $26.87 |
| 1976 | 145.0 | 28.2 | 44.3 | 0.31 | 0.33 | 23.24 | 28.19 |
| 1977 | 143.2 | 20.5 | 43.0 | 0.28 | 0.31 | 22.78 | 28.87 |
| 1978 | 194.7 | 46.9 | 41.4 | 0.34 | 0.32 | 30.87 | 32.35 |
| 1979 | 167.0 | 40.1 | 26.9 | 0.27 | 0.30 | 26.34 | 34.99 |
| 1980 | 248.5 | 67.6 | 43.5 | 0.35 | 0.40 | 38.88 | 51.32 |
| 1981 | 246.3 | 69.8 | 41.3 | 0.31 | 0.40 | 38.23 | 57.82 |
| 1982 | 262.6 | 41.7 | 43.5 | 0.31 | 0.46 | 40.51 | 69.61 |
| 1983 | 317.5 | 29.5 | 33.9 | 0.35 | 0.44 | 48.76 | 71.73 |
| 1984p | 354.1 | 27.8 | 30.6 | 0.36 | 0.41 | 54.08 | 71.01 |
| 1985p | 432.5 | 44.2 | 26.8 | na | na | 65.66 | 69.25 |
| 1975-85 | 2,684.9 | 41.7 | 36.6 | 0.33 | 0.37 | 37.95 | 49.27 |

Source: Health Information Division, Health and Welfare Canada, unpublished data.

Notes: a. New investments refer to expenditures on construction, repair, machinery, and equipment of hospitals, clinics, first-aid stations and homes for special care.
p. Preliminary data.

private and private rooms (Statistique Canada, 1986b). Currrently, provincial funding for a hospital is reduced by the amount of any profits received from the sale of auxilliary services. The revenue yielded by the charges for special accommodations, however, is divided equally between the hospital, the regional council and the provincial government; these funds are supposed to be used to finance hospitals' investment projects.

The hospitals could be encouraged to generate more revenue from such sources. Ontario has recently done this. In 1982 it introduced the Business Oriented New Development (BOND) program. Ontario hospitals are encouraged to raise money from the sale of ancilliary services by allowing them to keep all the profits from such sales and by greatly reducing the provincial regulations restricting the ability of the hospitals to do this. The wisdom of providing more funds for hospitals in this way is discussed briefly in Chapter V.

Several other forms of privatization which could involve some privatization of finance are described below: the further de-institutionalization of acute care services ("family care"), and the introduction of health maintenance organizations (HMOs) or of price-competition among health providers. Detailed analyses of these privatization schemes are presented in Chapters VIII and IX.

## Provision of Health Services

The province is not a major provider of health services. Very few physicians, dentists, pharmacists or optometrists, for example, are government employees. Those who are not self-employed work for non-government organizations; for example, a few physicians are employed by hospitals and most pharmacists work in privately owned pharmacies.

Furthermore, most in-patient services are not provided in government owned institutions. The province finances and regulates all the hospitals, but almost all Quebec hospitals are owned and operated by nonprofit organizations. According to Statistics Canada, as indicated in Table III, there were 241 hospitals in Quebec in 1985. Nonprofit "lay" organizations owned 193 of them; 87 percent of all beds were located in these hosptials. Only five were owned by the federal government and two by the Quebec government. Investor-owned (i.e. proprietary) hospitals currently have a very small role. The 41 proprietary hospitals--almost all in the rehabilitation-extended care sector--contain only 5 percent of Quebec's hospital beds.

The situation is somewhat different elsewhere, as indicated by a comparison of the data in Tables III and IV. There are very few investor owned hospitals outside of Quebec; 41 of the 58 proprietary hospitals in Canada are in Quebec. On the other hand, public ownership is much more common elsewhere; 42 percent of the hospitals outside of Quebec are publicly owned. Most of these are owned locally either by a hospital district or by a union of municipalities.

As well, among other residential institutions, the investor owned institutions are in the minority. As the data in Table V indicate, only 20.6 percent of these beds are in proprietary institutions in Quebec. The fraction is larger elsewhere; 31 percent of the beds across Canada are private.

The importance of nonprofit organizations in the health sector is underscored by the many nonprofit organizations which provide some form

## Table III
## Ownership of Hospitals[a]
## Quebec, 1985

| Ownership | | General | Specialty | Rehabilitation, Extended Care, & Psychiatric (Long Term) | Other | Total |
|---|---|---|---|---|---|---|
| | | Type of Hospital[e] | | | | |
| Lay[b] | Number | 121 | 13 | 59 | 0 | 193 |
| | Beds | 30,866 | 2687 | 16,332 | 0 | 49,885 |
| | Beds/Hosp. | 255 | 207 | 277 | 0 | 258 |
| Government[c] | Number | 0 | 1 | 1 | 0 | 2 |
| | Beds | 0 | 49 | 2222 | 0 | 2271 |
| | Beds/Hosp. | 0 | 49 | 2222 | 0 | 1136 |
| Proprietary[d] | Number | 2 | 0 | 38 | 1 | 41 |
| | Beds | 214 | 0 | 2611 | 21 | 2846 |
| | Beds/Hosp. | 107 | 0 | 69 | 21 | 69 |
| Federal | Number | 2 | 0 | 0 | 3 | 5 |
| | Beds | 1191 | 0 | 0 | 38 | 1229 |
| | Beds/Hosp. | 596 | 0 | 0 | 13 | 246 |
| Total | Number | 125 | 14 | 98 | 4 | 241 |
| | Beds | 32,271 | 2736 | 21,165 | 59 | 56,231 |
| | Beds/Hosp. | 258 | 195 | 216 | 15 | 233 |

Source: Statistique Canada, Division de la santé, Liste des hôpitaux canadiens et des établissements de soins spéciaux, 1985, Approvisionnements et Services Canada, Ottawa, catalogue 83-201, 1986.

Notes pour les tableaux III et IV:

a. "Se définit comme un établissement qui reçoit des personnes requérant des soins médicaux et leur dispense de façon continue ces soins ainsi que les services diagnostiques et thérapeutiques d'appoint et qui est enregistré or reconnu comme hôpital par une province our adminsitré par le gouvernement du Canada. Cette définition englobe quelques établissements psychiatriques.

b. "S'applique aux hôpitaux privés sans but lucratif. Hôpital reconnu par la province comme 'publique'.

c. La propriétaire de l'hôpital est une municipalité (y compris un comté, un district hospitalier ou une union de municipalités) ou la province.

d. "S'applique aux hopitaux reconnus par la province comme "privés à but lucratif"; il s'agit d'un hôpital qu'on particulier ou un organisme privé possède et exploite en vue de réaliser des bénéfices."

e. "Comprend 8,225 lits dans des 'Centres d'accueil" qui sont expoite par les hôpitaux."

### Table IV
## Ownership of Hospitals[a]
## Canada, 1985

|  |  | Type of Hospital |  |  |  |  |
|---|---|---|---|---|---|---|
| Ownership |  | General | Specialty | Rehabilitation, Extended Care, & Psychiatric (Long Term) | Other | Total |
| Lay[b] | Number | 481 | 27 | 115 | 9 | 632 |
|  | Beds | 94,051 | 5155 | 25,940 | 60 | 125,206 |
|  | Beds/Hosp. | 196 | 191 | 226 | 7 | 163 |
| Government[c] | Number | 369 | 10 | 38 | 0 | 417 |
|  | Beds | 33,357 | 1228 | 11,314 | 0 | 45,899 |
|  | Beds/Hosp. | 90 | 123 | 298 | 0 | 110 |
| Proprietary[d] | Number | 3 | 0 | 51 | 4 | 58 |
|  | Beds | 234 | 0 | 3309 | 120 | 3663 |
|  | Beds/Hosp. | 78 | 0 | 65 | 30 | 63 |
| Federal | Number | 17 | 0 | 3 | 103 | 123 |
|  | Beds | 2171 | 0 | 331 | 612 | 3114 |
|  | Beds/Hosp. | 128 | 0 | 110 | 6 | 25 |
| Total | Number | 870 | 37 | 207 | 116 | 1230 |
|  | Beds | 129,813 | 6383 | 40,894 | 792 | 177,882 |
|  | Beds/Hosp. | 149 | 173 | 198 | 7 | 145 |

Source: Statistique Canada, Division de la santé, Liste des hôpitaux canadiens et des établissements de soins spéciaux, 1985, Approvisionnements et Services Canada, Ottawa, catalogue 83-201, 1986.

Notes: Voir tableau III.

## Table V

## Ownership of Special Facilities[a]
## Quebec and Canada, 1985

| | | QUEBEC | | | CANADA | | |
|---|---|---|---|---|---|---|---|
| | | | Proprietary[b] | | | Proprietary[b] | |
| Type of Institution | | Total | Number | Percent of Total | Total | Numbers | Percent of Total |
| Aged Persons | Number | 708 | 195 | 27.5% | 2543 | 1141 | 44.9% |
| | Beds | 36534 | 8149 | 22.3 | 166463 | 60515 | 36.4 |
| | Beds/Facility | 52 | 42 | | 65 | 53 | |
| Physicially Handicapped | Number | 37 | 8 | 21.6% | 109 | 30 | 27.5% |
| | Beds | 1391 | 616 | 44.3 | 2847 | 1225 | 43.0 |
| | Beds/Facility | 38 | 77 | | 26 | 41 | |
| Retarded | Number | 0 | 0 | 0.0 | 733 | 175 | 23.9% |
| | Beds | 0 | 0 | 0.0 | 16839 | 1906 | 11.3 |
| | Beds/Facility | 0 | 0 | | 23 | 11 | |
| Mentally Handicapped | Number | 158 | 21 | 13.3% | 801 | 424 | 52.9% |
| | Beds | 5564 | 1100 | 19.8 | 24385 | 6359 | 26.1 |
| | Beds/Facility | 35 | 52 | | 30 | 15 | |
| Emotionally Disturbed Children | Number | 209 | 6 | 2.9% | 700 | 166 | 23.7% |
| | Beds | 4318 | 140 | 3.2 | 10405 | 1611 | 15.5 |
| | Beds/Facility | 21 | 23 | | 15 | 10 | |
| Alcohol & Drug | Number | 9 | 1 | 11.1% | 226 | 17 | 7.5% |
| | Beds | 285 | 20 | 7.0 | 5443 | 319 | 5.9 |
| | Beds/Facility | 32 | 20 | | 24 | 19 | |
| Delinquent | Number | 5 | 0 | 0.0 | 67 | 17 | 25.4% |
| | Beds | 350 | 0 | 0.0 | 1799 | 259 | 14.4 |
| | Beds/Facility | 70 | 0 | | 27 | 15 | |
| Transient | Number | 0 | 0 | 0.0 | 30 | 2 | 6.7% |
| | Beds | 0 | 0 | 0.0 | 2184 | 51 | 2.3 |
| | Beds/Facility | 0 | 0 | | 73 | 26 | |
| Other | Number | 52 | 1 | 1.9% | 398 | 59 | 14.8% |
| | Beds | 270 | 18 | 6.7 | 5551 | 832 | 15.0 |
| | Beds/Facility | 5 | 18 | | 14 | 14 | |
| Total | Number | 1178 | 232 | 19.7% | 5607 | 2031 | 36.2% |
| | Beds | 48712 | 10043 | 20.6 | 235916 | 73077 | 31.0 |
| | Beds/Facility | 41 | 43 | | 42 | 36 | |

Source: Statistique Canada, Division de la santé, Liste des hôpitaux canadiens et des établissements de soins spéciaux, 1985, Approvisionnements et Services Canada, Ottawa, catalogue 83-201, 1986.

continued

Table V, continued

Notes:

a. "Ne tient compte que des établissements résidentials de soins spéciaux comprenant au moins quatre lits pours les résidents autres que les membres du personnel et où des soins sont prodigués à au moins un résident. Ces établissements sont habituellement destinés à des malades ou à des invalides chroniques qui y séjournement de façon plus our moins permanente, par opposition, par exemple, à hôpital où les patients sont admis en fonction de leurs besoins médicaux et reçoivent des soins médicaux continus ainsi que des services diagnostiques et thérapeutiques.

b. "Particulier, association ou société constituée en corporation, quelle que soit l'aide financière accordée au propriétaire ou aux résidents, qui exploite l'etablissement en vue de réaliser des bénéfices."

of care to people who do not reside in a health care establishment. The Ministry of Health and Social Services provides financial support for hundreds of such organizations[7].

There are a variety of ways that the provision of services could be privatized. One set of proposals relates to changes in hospital management. First, the management of particular hospital services could be subcontracted to private firms. At least in principle, the management of most hospital services, support and clinical, could be subcontracted. With such subcontracting, the hospitals' facilities and employees continue to be used to produce the services, however. Although precise statistics are not available, many Quebec hospitals subcontract the management of some services. Second, the management of the entire hospital could be subcontracted. This was done at the Hawkesbury General Hospital in Hawkesbury, Ontario. Although this case has been widely cited, it is the only instance in Canada where the management of an entire hospital has been subcontracted to an investor-owned firm. Third, the goals of hospital management could be changed by selling existing hospitals to investor owned organizations, which would operate the hospitals in order to make profits. This would involve changing not only the goals of the hospitals, but also the management of the hospitals, as the new owners brought in new management teams.

There is some interest in making such management changes in Quebec. Indeed, le Groupe de travail has recommended all three of these types of changes in hospital management, though it would transform only small and medium sized establishments into investor-owned hospitals. Changing ownership is discussed in Chapter VI, and subcontracting management functions in Chapter VII.

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[7] Selon Bélanger (1985), "en 1983-84...le MAS subventionné plus de 700 organismes à but non lucratif, comprenant 457 organismes d'aide au maintien à domicile, 127 organismes de promotion et de services, 47 organismes d'aide aux femmes (maison de femmes) et 19 organismes d'aide aux jeunes (maison de jeunes)."

Another form of privatization would be to subcontract the actual provision of some services. A private firm could supply certain services itself, using its own employees and in some cases its own facilities. Support services and even some clinical services (e.g. laboratory services) could be subcontracted. At present there is very little of this subcontracting in Quebec.

Although it would not necessarily involve privatization in the strict sense of the term, managerial functions and services could be subcontracted to other hospitals rather than to investor-owned firms[8]. This is beginning to occur in Quebec.

The growing deinstitutionalization of acute care services--hereafter called "family care"--is another way to privatize services. This involves the shifting of important patient-care responsibilities from the hospital to the patient and his family, who are often supported by some sort of community or hospital-based home care program. This type of privatization can take a variety of forms, many of which already exist and could be expanded. For example, the hospitalization of some surgery patients is being avoided by the use of day surgery[9]. Attempts are also being made to reduce hospital stays by making available to discharged patients, young and old, an extensive array of home care services. Similarly, admissions to chronic care establishments and nursing homes may be avoided, proponents argue, by making such home care services available. Out-patient hospice programs may reduce some terminally ill patient's utilization of in-patient services. In addition, family members could be encouraged to provide routine nursing care for their hospitalized children; this will be called "parent care".

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[8] However, to the extent that a hospital acts as a subcontractor in order to earn extra money, there is little fundamental difference between subcontracting to a private firm and subcontracting to another hospital.

[9] This day surgery could be done at a hospital or a special "surgi-center", which is independent of any hospital. The latter have become a growth industry in the United States (Institute of Medicine, 1986).

In all these cases, a central element is the substitution of services provided by private individuals--patients and their families--for at least some services provided by hospitals. This is the reason that family care is a form of privatization. Actually, this involves the privatization of not only services, but also finance. Private individuals' services are replacing publicly financed services. This becomes even clearer if the patient must pay for some of the services received. For example, if a bed-ridden patient living at home must occasionally be brought to the hospital for tests or examination, this may require transport by an ambulance which is not publicly financed. Family care is evaluated in Chapter VIII.

Of course, this deinstitutionalization of acute care services is comparable to the deinstitutionalization of mental health services that has been occurring for several decades. Both are forms of privatization. The latter is the subject of other research projects supported by the Commission[10].

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[10] See the report of Guberman, Dorvil and Maheu and the two reports of Mercier.

## Management of the Health System

The extensive involvement of the provincial government in the management of the health system takes a variety of forms. First, legislation and regulations structure the environment in which the providers of services function. Second, the government influences the kinds of services provided by shaping investments in the system. Major investments in plant and equipment--however financed--require government approval, at least by the appropriate regional council and by the province if they involve large sums of money. The government also shapes our health manpower resources; for example, provincial policies determine the numbers of new doctors, dentists, nurses and physiotherapists who are trained each year.

Third, government is deeply involved in the determination of the prices received by many providers of services. It negotiates fee scales for physicians as well as wages and working conditions for hospital workers. It also is "involved" in setting hospital budgets, both by approving (determining) them prospectively and then by its willingness to finance deficits at year end.

Obviously, the privatization of the State's managerial functions could take many forms. With respect to prices, physicians and hospitals could be allowed to determine their own charges. There would probably be little interest in allowing them to behave like their American counterparts, who historically have been quite free to set their own rates, which the insurance companies then passively paid. However, extrabilling, which is discussed in Chapter IV, would give physicians and hospitals considerable control of their revenues.

Alternatively, the province could replace prospective budgetting for hospitals with a financing mechanism based on Diagnostic Related Groups (DRGs)[11]. DRG-based financing is now being used in the American medicare program, which reimburses hospitals for services provided people aged 65 and over. With this reimbursement method, Quebec would still set the rates for each DRG group. But it would no longer have to go through the annual ritual of evaluating and approving each hospital's proposed budget. As a result, its managerial functions would be reduced. Le Groupe de travail has recommended that the American experience with this financing mechanism be monitored closely. Hospital financing, however, is the subject of another report prepared for the Commission[12], so this issue will not be explored further here.

In addition, collective bargaining could be decentralized, as le Groupe de travail has also recommended. This issue is beyond the scope of this report, but collective bargaining in the health sector is also the subject of several other research projects sponsored by the Commission[13]. It is doubtful, however, that the province could ever fully extricate itself from collective bargaining, which has such important budgetary implications for it.

The partial deregulation of the health sector is a second possible type of privatization. Deregulation effectively shifts decision-making power from government to individual institutions in the health sector. The quantity of regulations, which touch all aspects of the health system, is very great; just the regulations for hospitals fill a book shelf. Unfortunately, although this could be an important area for reform, a careful evaluation of the existing regulations is beyond the scope of this report.

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[11] With DRG-based financing, a hospital receives a fixed amount of money for each patient, the amount depending only on the patient's diagnosed health problem. In the US version there are over 450 different diagnostic groups, each with its own fee, which is set by the federal government. The amount received for each patient is independent of the actual services received or the length of the hospital stay. Thus, with DRG-based financing hospital revenue is determined by the number of patients and their case-mix.

[12] Voir le rapport de Gilles Desrochers sur le financement et la budgétisation des hôpitaux.

[13] Voir les deux rapports de Jean Bernier.

Given the emphasis that has been placed on deregulation in other areas of government involvement, it is surprising that so little has been said about deregulating the health sector. The recent Groupe de travail sur la déréglementation (Québec, 1986a), for example, said nothing about the deregulation of the hospital sector. It did make a few comments which touch the health professions, however. It was primarily concerned about restrictions on nonhealth as well as health professionals' ability to advertise their services. This working group was also concerned that some professions have been overly protective of their exclusive right to perform particular services, greatly reducing the scope for competition and manpower substitution. It recommended that the government establish a permanent review mechanism to perform an on-going evaluation of the practice domains claimed by the various professions.

There is a third way to privatize management, which is receiving increasing attention: the primary responsibility for the provision of services for a defined group of people could be shifted from the State to another organization--some of the government's managerial functions could be shifted elsewhere. This type of privatization could take a variety of specific forms, though a common building block in most such proposals is an organization comparable to the American health maintenance organization (HMO). The HMOs would be responsible for providing their enrollees with necessary hospital and physician services, relieving the government of some managerial functions.

Health planners in Quebec have long been impressed by HMOs. Quebec's Castonguay Commission, for example, was certainly impressed by them. Its vision of the centres locaux de services communautaires (CLSCs), for example, was greatly influenced by the HMOs, though the vision actually implemented has proved quite different. Le Groupe de travail a recommandé "la création de nouveaux centres médicaux, appelés organizations de préservation de la santé (OPS), semblables à la formule américane des HMO...". Although health planners have been interested in HMOs, they have been unsure how in implant them and make them grow in Quebec.

One way would be to develop a network of HMOs in at least urban areas. The province would pay each HMO a fixed amount of money each year for each person enrolled with it. The HMO itself would then be responsible for providing its enrollees with needed health services. A variety of variations on this basic model are possible. For example, an HMO might be allowed to collect an annual membership fee from people who enroll with it. Such "private" HMOs would be to the health sector what the private schools are to the education sector.

Alternatively, The health system could be restructured so as to stimulate "price-competition" among a number of competing health plans some of which would be HMOs. The basic idea is that in a city like Montreal there would be a variety of organizations, including some HMOs, that would provide at least a basic package of hospital and physician health services to people who enrolled with them. Once a year Montrealers would enroll with one of these organizations, or opt to receive care in the conventional fee-for-service sector. Each "plan" would receive a per capita grant from the government for each person enrolled with it[14]. The grant would be sufficient (at least in theory) to pay for the basic package of services. A key feature is that the per capita grant would be the same for all plans; it would not vary according to each plan's actual costs.

Each plan would also be allowed to charge a "membership fee". A plan would need the additional revenue if it did not provide the basic set of required services efficiently, or if it wanted to provide a higher quality of care or more services than provided for by the per capita grant. Alternatively, if a plan had per capita costs less than the provincial grant, it could either give a rebate to its enrollees or use the extra revenue to finance a broader array of services. Thus, when people make their annual enrollment decisions among the competing health plans, they are envisaged as shopping around for the "best buy" in terms of membership fee, services and perceived quality.

"Price-competition" involves shifting some managerial responsibilites from the provincal government to the competing plans, at least the HMO plans. The province would specify the basic package of services and the per capita grant; then the competing plans would each decide how to provide the basic services and any others they elected to provide. Price-competition also involves some privatization of finance. The "membership fee" would shift some financial responsibility from government to private individuals.

This competitive structure is not an idea that has been widely discussed yet in Quebec, though a proposal along these lines has been prepared for the Commission[15]. This idea has seemingly received more attention in Ontario (Stoddart and Sheldon,1983; Muldoon and Stoddart,1986). Both HMOs and price-competition are ideas that will probably be widely discussed in the coming years, however, so they are reviewed in some detail in Chapter IX.

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[14] Here "plan" refers to one of the HMOs or the fee-for-service sector.

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[15] Voir le rapport de Stoddart.

## Chapter III
## PRIVATIZATION: WHAT ARE WE TRYING TO ACCOMPLISH?

Before analyzing the various privatization proposals, it is important identify the criteria that should be used to evaluate them. As with any proposed health system reform, privatization should be of interest to the extent that it would enhance the welfare of Quebec society. To judge whether proposed changes of the health system would improve social welfare, health planners have long based their evaluations of such proposals on the notions of "equity" and "efficiency". It seems reasonable to base this evaluation of privatization on them, too.

### EQUITY AND EFFICIENCY

There are several possible reasons why people might be interested in privatization. Some people appear interested in it because they see it as a source of additional profits. A consulting firm seeking new business might understandably be keen on hospitals subcontracting some of their management functions. But Quebec society might not benefit from subcontracting. For example, social welfare would be reduced if the profits resulted from a marked deterioration in the quality of patient care. Thus, profitablity is not a proper criteria for judging privatization proposals.

Similarly, physicians are always interested in the newest technologies. As a result, they would like to make greater use of private funding for new services to get around provincial budgetary restrictions. But Quebec society would not benefit from this if the costly new technologies had little effect on health. In fact, new services sometimes prove to be of minimal benefit. For example, coronary by-pass surgery is a costly procedure which has become widely used for various heart problems. But recent research suggests that it has been over-used (CASS, 1984). Similarly, electronic fetal monitoring became a standard procedure in delivery rooms in the 1970s. But on subsequent analysis, it too turns out to have been over-used (Banta and Thacker, 1979). Thus, physicians' interest in private funding is not a sufficient reason to expand it.

Some people are attracted to privatization purely for ideological reasons, stemming from their belief that government should have only a minimal role in people's lifes. The debate about privatization then becomes one about social goals, not one about how to make our health system work better. Evidence about the consequences of privatization for the health system is irrelevant in that debate. However, while ideology is an important element in the growing interest in privatization[1], there is no evidence that the vast majority of the Quebec population wants to eliminate government involvement in our health system. Indeed, programs like medicare and hospital insurance continue to be extremely popular.

But people are concerned that health services not be provided in a wasteful manner, and that reasonable access to effective services be assured for themselves and for others. That is to say, using vocabulary popularized by economists (for better or worse), people are concerned about the issues of efficiency and equity. If a government intervention enhances efficiency without compromising equity, then the program is socially desirable. Similarly, if some form of privatization would enhance efficiency without compromising equity, then it, too, is desirable.

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[1] Ideology must be an important reason for the attraction of many privatization schemes, judging by what is actually known about the likely effects of some of the more "popular" privatization proposals, as indicated in subsequent chapters.

Thus, when considering a specific privatization scheme, it is reasonable to ask whether there is reasonable evidence--theoretical and empirical--indicating that, if implemented, the scheme would improve efficiency without adversely affecting equity. But before turning to the evidence, it is useful to consider more deeply the meaning of these two magic words, efficiency and equity.

## The Meaning of Efficiency

Efficiency has two dimensions, both of which could be affected by privatization. One is that particular health services are produced at least cost: a service is provided efficiently if it cannot be provided at lower cost. If it now costs $10 to provide the evening banquet for each hospital patient, but the same dinner could be provided at $8 if the dietary service were reorganized, then the efficiency of this service could be improved by reorganizing it. Two dollars is being wasted. If the dietary service were reorganized, the $2 saved per dinner could be used to improve some other aspect of patient care services. Most people seem to associate the concept of efficiency with this idea of cost minimization.

Efficiency, however, has a second dimension, which relates to the mix of services being provided: the mix is efficient if the services being provided are all those for which the value of their benefits equals or exceeds their costs. If a team of doctors and nurses spend their time performing a surgical procedure which has no beneficial health effects, then they are wasting their time, particularly if there are patients with broken bones queuing-up downstairs in the emergency room. The waste here is as real as the waste in the dietary service across the hall, thus it is quite reasonable to view both situations as involving inefficiency. Society's interests would be well served if the waste in both the dietary and surgical services were eliminated.

Unfortunately, language is often used quite incorrectly. It is common for people to describe a reduction in spending as improving efficiency. But this is wrong. Efficiency does not imply expenditure minimization. The expenditures on dietary services might be reduced from $10 to $2 if meal portions were reduced by 75 percent. But such a cutback would not enhance efficiency because some patients would undoubtedly starve. Efficiency means avoiding waste, not avoiding spending. Spending is justified for services whose costs are warranted by their benefits.

Much has been said about the ability of Quebec and the other provinces to control their health expenditures the past 15 years. We sometimes (justifiably) point with pride to the fact that health expenditures are significantly lower in Quebec and the other provinces than in the U.S.[2] This pride is justified, too, to the extent that our expenditures are lower because we provide services at lower cost or because we provide fewer services that are of little or no value. But if our expenditures were lower because we were not providing some valuable services that the Americans were, our lower spending levels would be nothing about which to boast. If people in Quebec with some disease were forced to suffer, unlike their American counterparts, because we were unwilling to spend the additional $1,000 needed to cure them, then our lower spending levels certainly would not mean that Quebecers are better off than Americans.

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[2] In 1985 health expenditures were 8.48 percent of GNP in Canada and 10.63 percent in the US. Hospital expenditures alone were 3.45 percent in Canada and 4.17 percent in the U.S. (Health and Welfare Canada, unpublished data)

This distinction between efficiency and spending minimization will be important to bear in mind when reviewing the evidence relating to the consequences of various types of privatization. Because a reduction in expenditures does not necessarily mean an improvement in efficiency, one cannot judge whether a particular type of privatization would enhance efficiency merely because it would reduce hospital spending. To determine whether it would improve efficiency, one must consider not only its effect on spending, but also its effect on services provided. The reduced spending might stem from the elimination of a highly beneficial service. For example, closing all Montreal hospitals would reduce spending, but it would also reduce efficiency.

The assertion that the efficiency of our health system depends on the behavior of consumers, providers and the State is non-controversial. That the State can influence efficiency means that changes in the role of the State vis-à-vis the private sector may affect--for better or for worse--some aspects of efficiency.

In discussions of this sort, reference is frequently made to the effect of spending changes on the "quality" of care. A change in quality may relate to a change either in the nature of a particular service or in the mix of services which affects patients' welfare. If the dietary services tried to save $2 per meal by using week-old bread, for example, this would be a deterioration in quality. Similarly, if a hospital tried to reduce costs by eliminating dietary services, this too would be a deterioration in quality.

Equity

Equity has three dimensions, each of which can also be affected by privatization. One relates to the frequently expressed concern about "equity in access". At minimum this means that an individual's ability to pay should not affect his utilization of services, and that his utilization should not affect the money he has to spend on other goods and services (Fein, 1972). This requires not only that there be no financial incentives for users that cause differential access among people with different incomes, but also that comparable services be available for people of all income levels.

A somewhat stronger version of "equity in access" involves the idea that utilization should be determined by the "need" for beneficial services. This implies, for example, not only that ability to pay should not affect utilization, but also that residence should not either. People in the north who "need" services should have the same access as people in the urban areas. Although there has been improved access to services in rural areas during the past 15 years, this degree of equity has yet to be fully attained.

The second dimension of equity relates to the mechanism used by society to finance health services. As a general proposition, equity in finance is usually interpreted to mean that people should pay in proportion to their ability to pay, not their need for services. Thus, there has been widespread support for financing services from general tax revenues. The taxation system is usually presumed to be progressive, implying that people's tax burden rises with their ability to pay. As a result, public financing of health services is thought to be a progressive program, in that the value of services received may not vary too much among income classes while the tax burden increases with income (Boulet and Henderson, 1979).

A third dimension of equity relates to the treatment of people who work in the health system. Although concern about fair treatment of workers is not unique to the health system, thought must also be given to the consequences of privatization for health workers, from the lowest paid hospital workers to the highest paid physicians. Their wages and working conditions should be "fair". There is no yardstick indicating what is a fair wage, however. Rather, attention is focused on the process of determining wages, salaries, fees and working conditions. Collective bargaining is viewed as a reasonable process for determining them. Thus, if privatization interfered with collective bargaining, this aspect of equity would be reduced.

Certainly government involvement affects the degree to which equity is attained. Government can shape the structure of the health system, and structure has important implications for equity. For example, some financing mechanisms are more equitable than others. Government decisions about health spending also can affect equity. For example, the amount it spends can influence the availability of services for people with low incomes and for particular groups of people needing additional services (e.g. the handicapped and residents of rural areas). Spending levels also affect the pay of health workers.

## CURRENT PROBLEMS

Most observers agree that our health system has performed very well during the past several decades as a result of extensive government involvement in its financing and management. Quebec's health system is very highly regarded internationally, as well. But there are equity and efficiency problems to be resolved. Although this is not the place for an extended discussion of them, it is useful to list them in order to identify the problems in need of solution. Whether privatization can provide desirable solutions for them remains to be seen.

Briefly, it is still believed that some services could be provided at even lower cost, despite the budgetary pressures of the past 10 years. For example, the standard refrain--particularly when it is time to approve hospital budgets--is that there is still "fat" to be removed from the Quebec hospital network. These concerns are not limited just to hospitals and other publicly financed institutions. For example, Lomas and Stoddart(1985) have calculated that the cost of primary care medical services could be reduced by as much as 32 percent in Ontario if much greater use were made of nurse practitioners and less of general practitioners.

But increasingly the central issue is becoming the availability of beneficial services. On the one hand, there is widespread suspicion--at least among many health planners--that some services are being provided excessively, because a significant fraction of them are believed ineffective[3] or at least of little social benefit (relative to their cost). Consequently, it is argued that money could be saved by a much closer scrutiny of the services now being provided. Three examples indicate that there are a variety of reasons for this situation. First, we lack adequate knowledge about the health consequences of many services, old and new. There is no reason to think that all these services, if evaluated in a reasonable way, would prove beneficial[4]. Another reason is the substantial increase in the number of physicians per capita in Quebec during the past two decades (Soderstrom, 1985)[5]. The third reason is the way our system is structured. For example, our method of remunerating physicians, fee-for-service, rewards physicians financially for performing more services.

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[3] In a few cases the services have no favourable health effects for anyone. But most such cases involve services which benefit some, but not all of the people who receive them.

At the same time, at least some serious observers, citing reasons of both efficiency and equity, think more money is needed. Some argue that existing plant and equipment have been allowed to deteriorate, so substantial maintenance work is now desperately needed. Others argue that some highly beneficial services, particularly those associated with new technologies, are not being provided because of the scarcity of resources. Thus, hospitals and physicians have been arguing that there is a serious underfunding of health services. Still other observers wonder whether sufficient resources will be available to deal with emerging problems, associated, for example, with the aging population and new health problems like AIDS. There is also concern that long-standing problems, such as inadequate services for the handicapped and regional inequality in the availability of health services, are still not properly resolved. To what extent it is a funding problem as opposed to an organizational problem is not completely clear, but the continuing overcrowding in Montreal emergency rooms verges on the obscene. Finally, health sector workers--physicians to orderlies--argue that they are underpaid. This, of course, has been a big issue for the past 10 years.

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[4] Evans (1983) provides a good statement of this problem: "David Banta of the Office of Technology Assessment in the U.S. was recently quoted as saying that only 10 to 20 per cent of current health care interventions had been scientifically validated. Moreover, he said that the amazing thing about that statistic was not that it was so low, but that nobody had ever challenged it. I think that the reason that no one challenges it, is that they cannot."

[5] The counting of physicians is a difficult, for a variety of reasons. But whatever reasonable method used, there has been a substantial increase. According to one calculation, the number of physicians per capita increased 43 percent between 1972 and 1984 (Contandriopoulos and Fournier, 1986). According to another, it increased 35 percent between 1971 and 1984 (Health and Welfare Canada, 1986)

Thus goes the debate over health spending. Some say we spend too much; others that we spend not enough. Of course, we may be spending too much on some things, and too little on others. No attempt will be made to resolve this debate here. For present purposes, the important point is that, at least outside the halls of government, no one believes that current government involvement is beyond reproach.

Moreover, underlying this debate is the issue of professional vs. political control of the health system, as Evans has stressed[6]. Involved are several fundamental questions: what should be the role of "technical expertise" in shaping system performance and health policy? what should be the role of "collective choice"--of the State?

## THE ROLE OF THE STATE IN THE COMING YEARS

For at least the past ten years, the main focus of provincial health policy has been on limiting the growth of health spending, though at least until the mid 1980's real spending on both hospital and physician services in Quebec was increasing (Soderstrom, 1983a). Given the situation that prevailed in the mid 1970s, this focus was probably warranted. But, as a result of 10 years of budget pressures, the situation may now be different. Ten years ago, the claims of underfunding were not as widespread. But now, as just indicated, there are mounting pressures on government to increase spending for some services, while at the same time there is still room to reduce spending on some other services. How well can government be expected to perform in this much more complex situation?

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[6] See Evans( 1984), pp. 323-350, and Luft( 1983).

Some observers are concerned that its performance in the future will not be so good. There are at least two reasons for their concern. A brief review of them is useful not only because it indicates the difficulties that give rise to interest in privatization, but also because it helps clarify the criteria that should be used to evaluate privatization proposals.

One reason is related to the apparent fact that the basic problems now are more complicated than those which existed 10 years ago. Government may perform reasonably well when squeezing budgets is the necessary solution for prevailing problems, but some observers wonder how well it will perform when the problems are more complex, requiring much more sophisticated decision-making.

Of course, one must be careful of simplistic stereotypes. There is certainly no reason to think that the State is omniscient and always properly responsive to the public interest--any more than there is reason to think that private markets are omniscient and always properly responsive to the public interest, or that private enterprise in the health sector would behave like the firms that inhabit the economics textbooks and blackboards. But the case for government involvement has never rested on the idea that the State is omniscient and always properly responsive. Rather, the case for it is based on special characteristics of the health sector which imply that the involvement of the State--such as it does function--should enhance the efficiency and equity of the system (Soderstrom, 1983b; Evans, 1984).

One such characteristic is that physicians have special powers. Because people are inherently ignorant of medical matters, physicians shape their utilization of health services. One cannot stroll into the admissions office at l'Hôpital St-Luc and order an angiogram or some open heart surgery for oneself or a friend, as one can order a hamburger at Harvey's or an RRSP at Trust Royal. Physicians must do the ordering. Generally, this arrangement works well because we consumers know nothing about angiograms and open heart surgery. Sometimes, however, there are problems. As already indicated, the medical profession is often too eager to introduce widely new services. Moreover, physicians cannot give adequate attention to the cost consequences of their decisions (Luft, 1983). Value judgments are very important in shaping the provision of services, but the medical profession is not particularly well-suited to make many of the necessary judgments.

In short, the medical market is not like the markets described in economics textbooks--it is not like the markets for fast-food and for RRSPs. There are no well-informed consumers to present an effective countervailing force to the providers of services. The involvement of the State is needed to overcome this case of "market failure", to use the jargon of economics.

Second, there are special social values associated with access to health services. Quebec society is clearly concerned about equity in access and in finance for health services. Interestingly, however, it does not have similar concerns about other essentials like clothing, food, and housing. To facilitate equity in access, State involvement is needed in order to shape both utilization decisions and the availability of services.

In his new book the thoughtful American health economist Rashi Fein states the argument very well.

> "Reliance on government to ensure that the health sector utilizes an appropriate share of the nation's resources is not based on a misguided belief that the process of government decision making is smooth and without controversy. Nor does it assume that the various levels of government are always wise and responsive to the public interest or the public's desires. Government is cumbersome and is influenced by small but powerful and vocal groups.....The strength of government lies in another area. In the marketplace each of us votes with dollars, and that fact inevitably means that some have more votes than do others. In the political realm, conversely, each of us has no more or fewer votes than the next person (indeed, we are disturbed when we find that dollars invade and influence the electoral process and political decisions). There is little reason to think that the two voting systems would yield the same results. There is much reason to think that, though imperfect, the democratic method would more appropriately reflect the health needs of the total population[7].

Nevertheless, it is legitimate to ask whether some forms of privatization might usefully complement public involvement. Although the State will continue to be extensively involved in our health system in a variety of ways in the coming years, this does not preclude some restructuring of its present role if that could improve the preformance of the system. Such restructuring might involve changing how the State itself functions, or privatizing some current functions of the State. In either case, changes should be evaluated according to their effects on social welfare, as indicated by their consequences for efficiency and equity. That privatization would reduce State involvement *per se* is immaterial.

The second reason some health planners are concerned about the ability of the government to guide the health system properly relates to the government's current "fiscal crisis". Twenty years ago increased government spending was widely accepted. But now, reducing deficits and the size of government are fashionable. As a result of the current pre-occupation with reducing government spending, some people fear that the

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[7] Fein(1986), pp. 195-196.

State will starve the health system by continuing to squeeze budgets and to deny additional funding where needed. This is a legitimate concern.

Indeed, given the current emphasis on limiting government spending, it is tempting to evaluate the various privatization proposals in terms of their impact on government health spending[8]. But what is the rationale for doing that? Has reducing government health spending itself become a widely accepted social goal[9]? For some people, perhaps it has. But there is no convincing evidence that it has become a widely accepted social goal, as explained below. Moreover, a reduction in government spending does not necessarily mean an improvement in social welfare. If a cure for cancer were suddenly found, public financing would surely be forthcoming immediately, even if it raised government spending by 10 percent. What counts is how the public funds are being spent. If people think--rightly or wrongly--that tax dollars are being spent wastefully or inequitably, they will push for cutbacks.

But if they think additional spending would improve social welfare, they will support it. On this point, the results of a recent public opinion poll relating to public attitudes about government health spending are instructive. Although only a minority of the Quebec population thought there was insufficient spending, it was a surprisingly large minority (Contandriopoulos and Tessier, 1985). Based on a telephone survey of the Quebec population in April 1985, they estimated that only 45 percent of the population thought that the government was spending "assez"; 12 percent thought it was spending "trop d'argent" and 43 percent "pas assez"[10]. In addition, the survey indicated that 45 percent of the Quebec population was willing to pay a supplementary health tax in order to improve the health system. What makes this latter response so interesting is that so many people would support such a tax, even though people are constantly being told that government is already spending too much and there has been almost no public discussion of the usefulness of such a tax.

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[8] Two recent reviews of privatization have included the impact on government spending as one criteria for evaluating privatization (l'Association des hôpitaux du Canada, 1985; Stoddart and Labelle, 1985). In neither, however, is it the central issue.

[9] Reducing government spending could take the form of either actual cuts in spending, or slower rates of increase in spending.

The 1985 provincial election provides further evidence that the Quebec population has not become preoccupied with reducing government health spending *per se*. One of the main substantive issues debated was the adequacy of spending on health services. Increased spending for hospital services seemed to have considerable popular support. As a result, shortly after the election, the newly elected Liberal government commited itself to spending about 150 million additional dollars on hospitals over three years.

During the past 10 years, people have been told repeatedly that government was wasteful, and that there was much waste in the health sector. Thus, not surprisingly, efforts to reduce government spending by weeding out waste have enjoyed considerable popular support. But, as the foregoing poll and election results suggest, when people think that additional spending would improve health services, they are willing to support it. Government spending *per se* is not the issue; the use of our tax dollars is.

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[10] Quebec health administrators' attitudes are seemingly different from those of the population, the latter being seemingly more uneasy about current spending levels. At least this is the implication of some additional results reported by Contandriopoulous and Tessier, who also surveyed 205 participants at the "7$^e$ colloque Jean-Yves Rivard". Only 22 percent of them thought that the government was spending "pas assez" and another 22 percent that it was spending "trop d'argent".

To underscore this point, consider the frequently encountered argument that Quebec must turn to private financing because government can no longer afford to spend more money on health services. The image is of someone with only $100 to spend; once it is spent, the person has no more money. This image is dangerously misleading because government faces no such constraint. Suppose Quebec turned to private financing, by levying user charges for hospital services and by increasing the amount of private financing for hospital investments. Additional funds unquestionably would flow into the health system. This demonstrates that society is willing to pay more for health services. Thus, it is simply wrong to say that Quebec cannot afford to spend more on health. In fact, people are quite willing to provide more resources.

The real issue is not whether more resources are available, but how to channel the additional resources into health services. There are a variety of possible mechanisms. For example, society could use the apparatus of the State to tax the population and then to pay providers, or the apparatus of private insurance to collect premiums and then to pay providers. Alternatively, we could require that people pay directly for services. Finally, we could encourage people to make voluntary donations. Note that whichever mechanism is chosen, society ultimately pays. Which one is preferable? Unless one of them is socially preferable on ideological grounds, the choice should be dictated by the effects on social welfare. Thus, the role given to government financing should be determined not by imaginary resource constraints, but by the effects of this financing mechanism on efficiency and equity. Similarly, the role of private financing should be assessed by the same criteria.

To see this, suppose a user charge were levied on hospital services and that--as seems likely--it had no effect on utilization. Government spending would be reduced, but the total cost to society of hospital services would remain unchanged[11]. The only effect of this user charge would be to shift some hospital costs from the taxpayers to the sick. Consequently, despite the reduction in government spending, it is doubtful that many people would view this user charge as improving social welfare, given its negative effects on the sick.

Alternatively, suppose that the charge did reduce hospital costs for society as well as for government. Then society would at least receive some benefit from the user charge. Of course, even this cost saving might not be sufficient to warrant introducing the user charge. Consideration would still have to be given to the fact that the charge was a tax on the sick (i.e. equity effects) and the effects that it had on the health of people who reduced their utilization (i.e. efficiency effects).

## The Role of Privatization

The point here, however, is not that people want more health spending. This issue has only been used as a device to indicate it would be a mistake to evaluate privatization--or any other type of health system reforms--in terms of its impact on government spending. That would distort social values in Quebec. What people want is "value for their money", not necessarily less public spending. Whatever its effect on government spending, a privatization scheme which decreased efficiency (or equity) would not be socially desirable, while a scheme which improved efficiency (or equity) would be socially desirable.

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[11] Every dollar of user charges collected would reduce government spending by one dollar. Suppose hospital services cost $10. If government reduces its spending by one dollar and users then pay a dollar, hospital spending remains unchanged.

# Chapter IV
# USER CHARGES

With user charges, patients pay part of the cost of the services they receive. Thus introducing such charges would be an important way to shift some of the burden of financing health care to the private sector. The current discussion of users charges centers on two forms: deterrent charges and extrabilling. Both are considered here.

During the past 15 years much has been written about user charges, pro and con. No attempt is made here to provide a comprehensive, detailed review of this literature; the standard reference on user charges is Barer, et.al. (1979). Instead, the issues involved in the debate over user charges are summarized, and some important recent empirical evidence regarding the consequences of deterrent charges is reviewed. The special tax-based deterrent charge scheme proposed by le Groupe de travail (Québec, 1986b) is also evaluated.

## RATIONALE FOR DETERRENT CHARGES

The basic structure of a deterrent charge scheme for physician (or hospital) services is simple. The government would prescribe what users had to pay for each physician (or hospital) visit[1]. Patients would pay the charge directly to providers from their own pockets; the charge would not be covered by any supplementary health insurance plan. The total money received by the physician per visit would not change, however; the government would reduce physicians' fees by the amount of the charge[2]. At least some of the poor and the aged would be exempted from paying deterrent charges.

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[1] There are many possibilities. The government could prescibe a fixed sum of money, say $2 per visit. It could require that people pay a percentage of the cost of services rendered, say 25 percent. It could also stipulate that people would pay only a certain amount for user charges during the year, say $500. Deterrent charges are also referred to as coinsurance, authorized charges, copayment, cost sharing, deductibles, etc.

Deterrent charges are supposed to reduce health costs. This is certainly their most attractive rationale[3]. Proponents rightfully note that some health services are of little value, so not worth their cost. They then argue that if consumers had to pay something out-of-pocket for services received, they would be deterred from using services of little value. The resulting reduced utilization would yield reduced costs and increased efficiency. The amount of the reduction in usage and costs, of course, would depend on the size of the deterrent charge and on how sensitive consumers' utilization decisions were to out-of-pocket costs. Society would benefit because the total cost of health services would be reduced without sacrificing highly valued services. The government would also be happy because its spending would also be reduced, because the amount it paid for each service would be reduced by the amount of the deterrent charge.

## Three Concerns

First, many health planners doubt that deterrent charges actually would significantly reduce health costs. The impact of deterrent charges on costs would depend on more than just consumers' initial utilization decisions, the critics argue. Other people in the health system would also be affected, so allowance must be made for their reactions (Hester and

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[2] Suppose the government and the physicians agreed that physicians should receive $25 for an office visit. When the government introduced a $4 deterrent charge, the fee paid by the RAMQ would drop to $21.

[3] For example, governments are sometimes attracted to deterrent charges because they are a way to reduce government spending. But, as explained in Chapter III, this is of no social benefit.

Leveson, 1974). When allowance is made for them, cost savings no longer seem likely, the critics conclude.

By way of illustration, consider the consequences of a deterrent charge for physician services. The initial reduction in usage as consumers respond to the new charges would reduce physicians' incomes. This would not make physicians very happy, so they would look for ways to protect their incomes. Collectively, the general practitioners and the specialists could press for higher fees at the next round of fee negotiations. Individually, they could provide more services to patients. Finding themselves with a little more time on their hands, individual physicians could perform more tests, suggest people return of another follow-up visit, do more surgery, etc. They could also provide more expensive services, performing, for example, a complete examination where formerly they would have done an ordinary examination. Consumers being inherently ignorant about medical matters, the physician is the gatekeeper to the health system. As a result, when they want to protect their incomes, they can swing open the gate a little wider without too much difficulty (Evans, 1984). The higher fees for all services, the physician-induced utilization increases, and the shift toward more expensive services would at least partially offset the initial cost reduction caused by the consumers' initial response to the new charges.

In addition, allowance should also be made for higher administration costs. Collecting the fees and granting fee waivers to the poor and the aged would involve some cost. Moreover, the critics argue, the deterrent charge might cause some people to delay seeking care, resulting in higher treatment costs. It is often much cheaper to treat someone early in the physician's office than to delay treatment until the person is brought to the hospital by ambulance.

The second concern about deterrent charges is their effect on people's health. Although physicians may now be rendering many services of little or no value, there is no reason to expect that any reduction in utilization would be limited just to such services. Being inherently ignorant of medical matters, consumers are often not in a good position to judge the value of a physician office visit, at least before they actually go. If the kid is vomiting and has a fever, is it only influenza or meningitis? Thus, when faced with a deterrent charge, some people understandably might forego some beneficial services as well as some that are not, and their health would suffer[4].

The third concern of the critics is that deterrent charges would adversely affect social equity. Their argument has two elements. One is that the negative utilization and health effects would be borne disproportionately by the poor. The charges would be of greater financial consequence for low income families than high income families, so the poor would be more likely to forego services. Of course, advocates of deterrent charges usually stipulate that the poor be exempted from paying the charges. But this is easier said than done. For example, how would the "poor" be defined? Typically, the definition is very narrow. When deterrent charges were levied in Saskatchewan in the late 1960s, the poor included only the people on social welfare. How would people establish their eligiblity for a waiver? If they had to approach a government agency and ask for it, many might prefer not to ask for it. And many who did might get caught-up in red tape. For example, the majority of people in Ontario in the late 1970s who were eligible for reduced health insurance premiums did not actually have them (Canada, 1981). Would the physicians be reimbursed for the charges they could not collect? If not, physicians would find such patients less attractive financially.

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[4] Parenthetically, user charges are often justified by arguing that they would eliminate "abuse", particularly "abuse" of emergency room services. But what does "abuse" mean? Perhaps it means seeking care for services of little value. It is not clear, however, why one should expect people to eliminate only such valueless services. As just explained, it is unreasonable to expect that people can always judge the value of seeing a physician. Alternatively, "abuse" may mean using the emergency room for "inappropriate" reasons. But if there is much such use, one should probe more deeply to discover why people are using it inappropriately and whether deterrent charges would actually eliminate any such usage. If people are coming in the evening, for example, because they cannot find a physician elsewhere, then it is not clear that user charges would be the proper remedy.

In addition, the critics also argue that social equity would be compromised because deterrent charges involve a redistribution of income of dubious merit. As explained in Chapter III, such charges involve replacing government spending financed by taxpayers with payments made by the sick. To the extent that our tax structure is progressive, a deterrent charge would in many cases involve a redistribution of money from a low- or modest-income family with someone sick to a high income family (Boulet and Henderson, 1979). This would be inconsistent with the principle of finance according to ability to pay.

## DETERRENT CHARGES: THE EMPIRICAL EVIDENCE

After 20 years of research the empricial literature is large, but unfortunately not very informative. There are many studies which suggest that deterrent charges reduce utilization, but their reliability is often questionable. More importantly, there is very little reliable evidence that deterrent charges reduce health costs. Many people have merely assumed that if utilization were reduced that costs must be reduced, too. But, as just explained, this assumption is unreasonable. Moreover, although the health effects are a central issue in the debate over user charges, there is little useful information for judging whether these effects were important. There is some evidence, however, indicating that deterrent charges can negatively affect the poor.

Only the findings from two of the most recent, important research projects are reviewed here. In a series of papers, Beck and Horne have presented an analysis of some effects of deterrent charges in Saskatchewan between 1968 and 1971. These results are interesting because they provide some indication of the effects in a Canadian context. It is certainly important to review as well the available results from the RAND Health Insurance Experiment in the U.S. conducted in the late 1970s. All the results are not yet available, but this research has already attracted considerable attention, pro and con. It is the one study, for example, which provides some information about the health effects of deterrent charges.

## The Saskatchewan Experience

For 40 months between 1968 and 1969 deterrent charges were levied for physician and hospital services. For example, there was a charge of $1.50 for a physician office visit[5]. This was a substantial charge. It is equivalent to a charge of $4.98 in 1986 dollars, and it represents one-third of the revenue received by the physician for the visit. At the same time, there was a $2.50 per day charge for the first 30 days of acute care hospital services. This was equivalent to $8.31 in 1986 dollars. Only social assistance recipients were excluded.

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[5] The program was in effect between April 15, 1968, and July 31, 1971. Beside the charge for the physician office visit, there was a $2.00 charge of a home, emergency room or hospital out-patient department visit. There was also a $2.50 charge per day for the first 30 days of acute care hospital services, and a $1.50 charge for the next 60 days. There was a ceiling on the annual cost of the charges, however, of $180 for a single adult or family.

There were apparently some reductions in the utilization of physician services. Beck and Horne(1980) report an average annual reduction of 5.7 percent in the use of services. Beck(1974) reports a reduction of between 6 and 7 percent in 1970. The Saskatchewan Medical Care Insurance Commission reports a reduction of 7.2 percent in 1970 (Saskatchewan,1971).

Unfortunately, they present no evidence regarding the effects on total health spending. Indeed, costs may not have fallen. Saskatchewan physicians received two fee increases while the scheme was in force. Moreover, there is some evidence of a change in composition of acts performed. For example, between 1968 and 1971 there was a 16 percent reduction in low cost regional examinations and a 31 percent increase in high cost complete examinations (Beck and Horne, 1980). Thus, it is not surprising that "...Gross payments for medical services increased by 13.49 percent in 1969, the largest increase in the seven year history of the medical care plan. The increases for 1970 and 1971 of 11.88 and 12.23 percent also exceeded the pre-copayment rate of increase." (Badgley and Smith, 1979).

Beck (1974) presents some evidence that the utilization of services declined disproportionately more among low-income families[6]. He found that the utilization of physician services in 1970 was reduced by 18 percent among low-income families, while it was reduced by only 6 to 7 percent for all families.

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[6] A family was defined as poor if its income did not exceed the poverty income level used by the 1969 Senate Committee on Poverty.

The hospital charges apparently had only a negligible effect on hospitalization. Beck and Horne(1980) argue that there was no copayment effect on either the probability of a family having someone hospitalized or the length of time they were hospitalized. This does not mean that the charges were of no consequence, however. As Beck and Horne stress, they did result in an income transfer from the sick to higher income taxpayers.

Thus, this analysis of the Saskatchewan experience suggests the impact of the substantial charges on costs was at best probably small; there was no effect on hospital costs and probably only a very small effect on medical costs. No evidence was presented regarding the health effects. Judging from the utilization data, low-income families bore a disporportionate share of the burden of the charges.

## The RAND Study

In the early 1970s a group of researchers at the RAND corporation organized a health insurance experiment involving a handful of residents at 6 sites scattered across the U.S.. This experiment is too complicated to describe in detail here, but information is readily available elsewhere (Newhouse et.al., 1981).

A key feature of the RAND experiment is that participants were randomly divided among 14 health insurance plans covering hospital, physician, and dental services plus prescription drugs. There was one plan providing "free care" and 13 "nonfree" plans involving different deterrent charges and limits on family out-of-pocket spending. These 13 plans provided a mixture of various coinsurance rates[7]--25, 50 or 95 percent--

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[7] A coinsurance rate is a deterrent charge, though the amount of the charge is not a predetermined sum of money. Rather, the charge is a predetermined percentage of the cost of services received.

and various ceilings on family out-of-pocket costs--the minimum of either $1,000 or, depending on the plan, 5, 10 or 15 percent of family income. In most cases, the coinsurance charge was levied on the cost of all services.

The use and cost of services for people in both types of plans were monitored for between three and five years. High income families as well as people 62 and over were excluded from the experiment. Thus, these results provide no information about the consequences of deterrent charges for older people.

There are interim results relating to utilization and expenditures for children (Leibowitz et.al., 1985) and adults (Newhouse et.al.,1981), and to the health effects for children (Valdez, 1986) and adults (Brook et.al., 1983, 1984). The interim results relating to the use of hospital emergency rooms are for both children and adults (O'Grady, et.al., 1985), while those regarding the inappropriate use of hospital inpatient services are only for adults (Siu et.al, 1986). Other results have also been published, but these studies provide a good representation of the findings.

## RAND: Expenditure and Utilization Effects

Total expenditure per capita was significantly lower for people in the "nonfree" plans than for those in the "free" plan[8]. However, it might require a substantial deterrent charge to produce this effect, at least for adults. For them, statistically significant reductions in expenditures apparently occurred only for the plans with 95 percent coinsurance[9]. Expenditures per adult where 35 percent lower for adults in the 95 percent coinsurance plans than for adults in the free plan.

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[8] Note that when calculating the cost of the nonfree plans no allowance was apparently made for the higher administrative costs of running a plan with deterrent charges.

[9] Certainly there is no significant difference in total expenditures between the free plan and the plans with the more modest 25 percent coinsurance rate. (Leibowitz et.al., 1985, p.5)

For children, however, the impact on total expenditures is stronger. Total expenditures were significantly lower statistically for children whose families were in the plans with 50 and 95 percent coinsurance, and almost so for those in plans with 25 percent coinsurance. Expenditures per child where 45 percent lower for children in the 95 percent coinsurance plans than for children in the free plan.

Expenditures for ambulatory medical services were lower for both children and adults in the nonfree plans because these people made less use of ambulatory services than people in the free plan. People in the nonfree plans had a lower probability of seeing a physican each year, and fewer emergency room visits. In addition, adults in the nonfree plans had fewer outpatient hospital visits, and children, fewer physician visits per year.

The effect of deterrent charges on per capita expenditures for inpatient hospital services is not so clear-cut. For children, the deterrent charges apparently had no effect on hospital utilization or expenditures. On the other hand, adults in the nonfree plans had a significantly lower probability of being admitted to hospital. But the average cost per case for adults was the same for all plans, free and nonfree[10]. Thus, the deterrent charges apparently reduced hospital spending, though data are not presented showing that total inpatient costs per adult actually were significantly lower for adults on the nonfree plans.

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[10] It is not clear whether this is because case-management decisions for hospitalized patients were unaffected by deterrent charges or because ceilings on annual family expenditures for the charges were sufficiently low that people who were hospitalized quickly reached this ceiling and were then no longer subject to charges. Newhouse et.al( 1981) offer the latter explanation.

There is a striking pattern in the expenditure data for services other than ambulatory services. These "other expenditures" include spending not only for inpatient hospital services, but also for dental services, prescription drugs and some miscellaneous other items--all of which were covered by the RAND insurance plan. "Other expenditures" per adult were the same for all plans. Other expenditures per child, however, were lower for children in all nonfree plans. This suggests that the major source of reduced health spending for adults on the nonfree plans was reduced usage of ambulatory services[11]. But for children, deterrent charges reduced their usage of ambulatory medical services and other nonhospital services.

The effects of nonfree care on total health expenditures were the same for high-income and low-income families. The effect of nonfree care on the utilization of emergency room services was apparently different for people from low-income families; unfortunately, little information is provided about the nature of this effect, however.

## RAND: Health Effects

Judging from a variety of process measures, the deterrent charges do adversely effect health. The emergency room usage was significantly lower for people in the nonfree plans. For laceration cases involving sutures the visit rates, not surprisingly, were the same for people in both types of plans, but for cases not involving sutures, the visit rate was much lower for people in the nonfree plans. Moreover, for the people in the nonfree plans, accident-related visits per capita were only 69 percent of the accident-related visits for those on the free plan. Similarly, for the people in the nonfree plans, nonaccident-related visits per capita were only 66 percent of the nonaccident-related visits of those in the free plan.

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[11] At least, any reduction in spending for inpatient hospital services for adults was just offset by increased spending of dental services, etc.

The RAND researchers also split the 26 diagnostic groups with the most number of emergency room cases into "more urgent" and "less urgent" categories. For the "more urgent" category as a whole, the visit rate for people in the nonfree plans was only 77 percent of the rate for those in the free plan[12], and for the "less urgent" category, only 53 percent as large[13].

Another team of RAND researchers employed a group of physicians to evaluate the appropriateness of hospital admissions for adults, using a pre-specified protocol. These physicians found that 23 percent of the admissions were "inappropriate", most involving cases for which no acute care services were either needed or provided during the first 24 to 48 hours following admission[14].

These results also suggest that deterrent charges can adversely effect people's health. The deterrent charges had no effect on inappropriate use. The fraction of admissions and total hospital days that were judged inappropriate was the same for people in the free plan and the nonfree plans. If people were able to determine the benefit of hospitalization, one would expect those paying deterrent charges would reduce their use of hospital services largely by eliminating "inappropriate" utilization. But this did not happen. For the people in the nonfree plans, the reduction in admissions involved equal reductions in "appropriate" and "inappropriate" services. Thus, people subject to the deterrent charges had 22 percent fewer "appropriate" admissions per capita!

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[12] For asthma cases the visit rate for people on the nonfree plan was only 36 percent of the rate of the free plan, for otitis media 51 percent, for urinary tract infections 51 percent and for fractures or dislocations 80 percent.

[13] For cases involving abrasion or contusions the visit rate for people on the nonfree plan was only 54 percent of the rate for the free plan, for sprains 63 percent, for upper respiratory infections 51 percent, and for influenza 65 percent.

[14] In light of the discussion in Chapter VIII regarding day surgery, it is interesting that they also found that another 17 percent of the admissions could have been avoided by greater use of ambulatory surgery.

Outcome measures of health, however, suggest that the health effects are only minor--at least this is the interpretation placed on these results by the RAND researchers. For adults, they used 11 health status measures, and for only 2 did adults in nonfree plans have worse health outcomes. For five general health perception indices, there were no differences for the adults on the two types of plans[15]. Similarly, there were no differences in the adults' smoking habits, weight, and serum cholesterol levels. Moreover, the calculated risk of dying from a health problem related to smoking, weight, cholesterol or high blood pressure was the same for adults in both types of plans.

Only for two physiologic measures related to blood pressure and vision was the "health" of adults on the nonfree plans significantly worse. In the published article, the researchers also present some evidence with respect to these two measures suggesting that low income people with elevated risk may have experienced larger negative effects from being in the nonfree plans than higher income people (Brook et.al., 1983). But in a later report the evidence is more ambiguous (Brook et.al., 1984).

For children the RAND researchers used five physiologic measures--functional far vision and the existence of anemia, hay fever, hearing loss, and fluid in middle ear--and three general health perception indices. For none of these eight measures was there a significant difference between the values for children on the free and nonfree plans.

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[15] These five general health indices were constructed using questionnaire results: physical functioning, role functioning, mental health, social contacts, and health perceptions.

RAND: Commentary

Although the expenditure and utilization results are plausible, they are of no use for judging the consequences of introducing deterrent charges in Quebec. We would like to know what the effects would be on system performance of introducing a deterrent charge scheme covering the entire population. Confronted by a deterrent charge, it is certainly plausible that some consumers probably would elect to reduce their usage of services. But, as explained earlier, other elements of the system would probably react, too. How important would these latter responses be? Would they be such that there would be no significant cost reduction? This is the key research question. Unfortunately, the RAND results tell us nothing about the importance of these system responses.

This is because the RAND experiment only relates to a handful of people at each of the 6 sites. For example, at Dayton Ohio only 0.11 percent of the population was covered, and at Seattle, only 0.07 percent. Consequently, because there were so few people involved at each site, the effects of the experiment on the system at each one was imperceptible. Thus, there were no system reponses[16]. What RAND has measured is only the effects of individual consumer's decisions on their own utilization of services. No one should be surprised by what they have found.

The RAND results, for example, provide no information about physicians' probable reactions because the physicians at any site were unaffected by the experiment. Because there were so few people participating at any site and because they were randomly chosen, the few physicians who were even touched by the experiment probably had only one or two families participating in it. As a result, any changes in the families' behavior had no perceptible effect on that physician's workload or income. Thus, there is no reason to expect that physicians' behavior was affected by the experiment. This is certainly very different from the situation which would prevail if everyone in the area were subject to deterrent charges.

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[16] Moreover, if there were any effects, the RAND researchers would not detect them because they monitored only the behavior of the few people in the experiment at each site, not everyone living in the area.

The results regarding the health consequences are also questionable for the same reason. Nevertheless, they are still quite interesting. Because so very little information has been available about the health consequences of deterrent charges prior to the RAND study, even this fragmentary evidence is useful. It provides a detailed picture of the health consequences of the individual consumers' own utilization decisions. As explained earlier, a basic concern about deterrent charges is that they force consumers to make decisions that they are ill-equiped to make. What does happen, then, when consumers do make price-induced utilization decisions?

The RAND results seem sobering: the results with respect to health outcomes suggest that substantial differences in utilization do not have much effect on the health of either adults or children. This, of course, is not an unreasonable possibility, given all that has been said about "ineffective" services during the past 15 years. But there are some problems with the RAND health research, which make it difficult to accept that conclusion at the present time[17].

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[17] If subsequent analyses do support this results, however, it would not necessarily be wise to opt for deterrent charges. Such results suggest that health services have little impact on health. A much more appropriate policy response should involve an immediate, widespread review of services currently be provided. Deterrent charges may deal with only the tip of the iceberg.

First, the nature of the outcome measures themselves makes that basic conclusion problematical. With respect to adults, for the two measures for which one would guess *apriori* that physician services should make a difference--blood pressure and vision--the RAND researchers do find that there are differences between people in the two types of plans. On the other hand, it comes as no surprise that deterrent charges had no effect on adults' weight, smoking practices or cholesterol; these involve habits that one would be very surprised if physicians could change. Thus, these results for health habits do not bolster the case for deterrent charges.

It is puzzling, however, that there were no appreciable effects for any of the the five general health perception indices. It is particularly puzzling that perceived health status was the same for people on the free and the nonfree plans. One possibility is that these results are correct. Another, however, is that these questionnaire-based measures are simply not very "sensitive" to differences in health caused by differences in the utilization of health services. Although the RAND researchers have made some indirect calculations suggesting that these measures for adults should be sufficiently sensitive for their purposes, the fact is that there is no direct evidence establishing a meaningful relationship between any of these five measures and people's "actual" health (Brook et.al., 1979).

Secondly, it would be much easier to accept the RAND researchers' conclusion if they could show that plan membership had no effect on more aspects of health for which most informed observers would bet that medical care was important. Unfortunately, to assess adults' health these researchers have used only two such measures, blood pressure and vision.

Other reviewers of the RAND results have also expressed concern about this issue (Relman, 1983; Stoddart and Labelle, 1985).

These RAND results differ from other fragmentary information available about the health effects of user charges. When Enterline and McDonald studied the health effects of medicare in Montreal, they used a variety of physiologic measures to assess the health outcomes. Their results suggest that health does suffer when people must pay something out-of-pocket for health services (McDonald et.al.,1974).

More physiologic measures were used for children, of course. But the five used do not present a comprehensive picture of child health. Moreover, one wonders whether these are the type of health problems for which parents would likely forego services when confronted with user charges.

Thirdly, the RAND sample may be too small to detect a variety of important health effects that would emerge if an deterrent charges were applied to an entire population. For example, suppose the deterrent charges caused a few families to delay taking their sick child to the hospital, and that it turned out that the child had meningitis and died because of the delay before being treated. Could the RAND researchers pick-up this effect? It does not appear than they could.

Finally, the process measures provide a very different picture of the health implications of the deterrent charges. Of course, the linkage between "process" and "outcome" is often a very loose one at best (Brook, 1974). But is it so loose that the substantial differences in the usage of emergency room services was of no consequence for the health of the people in the nonfree plans? Or that a 22 percent reduction in "appropriate" admissions was of no consequence for adults' health either? Children in the

95 percent coinsurance plans had 41 percent fewer annual outpatient episodes of care. Are child health services so inconsequential that this was of no consequence for their health?

Another striking aspect of the RAND results is that the effect of deterrent charges is so weakly related to family income--if it is at all related to it. But it would be incorrect to conclude from these results that there would be no differential effects if a deterrent charge scheme were introduced in Quebec. There are at least two reasons for this. First, people 62 and over were excluded from the study, so many low income people were not part of the experiment. Second, because of the structure of the nonfree plans, low income families had lower limits on their out-of-pocket expenditures than higher income people did[18]. Consequently, as the RAND researchers note, more of the low income people exceeded the ceilings and were not subject to deterrent charges during part of the year. Of course, if a scheme were introduced in Quebec that did not have this feature, low income people might well experience differential deterrent charge effects[19].

Note, however, that this feature of the RAND schemes also makes them a very regressive way to finance health services. Recall that the maximum expenditure was $1,000 for all plans. Now, consider two families in a 10 percent coinsurance plan, one with an income of $9,000 and the other with an income of $30,000. Suppose both have already spent $900 out-of-pocket on user charges. It must be some consolation to the poor family that after spending 10 percent of its income on user charges that all additonal services will be free. On the other hand, the unfortunate high income family will not have free care until it spends $1000--3 percent of its income.

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[18] Among the nonfree plans, for each deterrent charge there were three plans: one for which the maximum family expenditure was at most 5 percent of family income; one for which the maximum was 10 percent ; and one for which it was 15 percent. In all three cases, the the maximum family expenditure was $1,000. Thus a low income family was more likely to hit the ceiling sooner than a high income family.

[19] Another possibility is that, given the poor health insurance coverage of many low income families in the US, being on the RAND experiment even with deterrent charges may have provided these families with better coverage than they had in previous years. The better coverage might have resulted in their making greater use of the plan than would occur if they were in such plans for a long period of time.

Thus, the RAND results provide little useful information for judging the likely effects of introducing a deterrent charge scheme in Quebec. They do not indicate what the expenditure effects would be. They provide limited information about the utilization and health effects by income class. If anything, they warn that there could be significant negative health effects.

## TAXATION OF HEALTH BENEFITS

Le Groupe de travail (Québec, 1986b) has proposed taxing publicly financed health benefits. According to its proposal, the government would provide each Quebec resident with an annual statement indicating the total value of publicly financed services he received during the year. This sum would then be added to his personal income and subject to provincial income tax. Le Groupe de travail proposes taxing only the first $1500 or $2000 of benefits. It also proposes that tax rates should be lowered slightly for everyone so that the province would not gain revenue from this scheme.

### Equivalent to a Deterrent Charge

The money collected, it is quite clear, would be a deterrent charge. The main difference between this proposal and conventional deterrent charge schemes is that the charges would be collected through the income tax system rather than by the providers themselves. But this does not change the fundamental fact that the amount one would pay would be determined by one's utilization of health services. People who used no services would pay nothing. People who used $100 worth of services would pay much less than people who used $1000; in both cases the amount paid would depend on people's marginal tax rates[20].

This scheme is quite different from a special health tax, which might be levied to raise revenues for health services. A health tax could also be collected through the income tax system. But the amount one paid would depend only on one's taxable income and marginal tax rate; it would be independent of the value of publicly financed health services one used during the year.

This form of a deterrent charge does have some advantages over conventional schemes. The actual amount of the charge would be income related; because the tax rates rise with taxable income, people from low income families would pay less than people from high income families. The charge would also be affected by family size. In addition, this scheme would provide a simple mechanism to reduce the amount of the charge paid by someone who had unexpected short-term financial problems during the year[21]. Finally, everyone eligible for reduced charges would receive them. This scheme would avoid the situation where a low-income family would have to apply to some administrative body for a special reduction in the charge they had to pay.

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[20] For example, suppose someone had 10 physician office visits during the year, each costing the province $25. The value of publicly financed health services would be $250. If the marginal tax rate for this individual were 20 percent, then she would pay a deterrent charge of $50 for the year, or $5 per visit.

[21] In conventional plans, there would have to be an administrative mechanism to waive the charge for people who had unexpected financial problems during the year.

But this scheme certainly would not avoid the important negative features of conventional deterrent charge schemes. There would be additional administrative costs because the cost of services received by each taxpayer would have to be calculated carefully and distributed to them. These additional administrative costs plus the effect of the reactions of providers would probably mean that any cost savings would be insignificant. In addition, people would probably forego some beneficial as well as nonbeneficial services. Finally, this scheme makes clear that deterrent charges are a tax on the sick. The sicker a person, the more his tax would be. The revenue would be used to reduce the tax rates for everyone, sick or not. If all rates were reduced proportionally, the big beneficiaries would be high income families. Incidently, using the revenue from the charges to reduce tax rates means that it would not be available to fund new services. People who view user charges as a source of private funding for new services will not find this feature appealing.

## Simulated Effects

To obtain a rough indication of the financial consequences of this scheme for users of services, 1982 Quebec income tax data, the most recent available, were used to estimate the personal out-of-pocket cost of services received. Using this data, one can calculate the average taxable income for people in various total income groups. Then, one can use the tax table to determine the relevant marginal tax rate for the "average" person in each income group[22]. Unfortunately, data are not available indicating the value of services received by people in each income group. But the results obtained based on the assumption the value of services would be the same for people in all income groups are still interesting. If anything the results understate the relative financial burden that would be borne by low income families[23]. The results of these calculations are presented in Table VI.

For example, in 1982 the RAMQ paid $14.53 for the average office examination. Thus, the average person with a total income between only $4,000 and $5,000 would have paid $1.89 out-of-pocket. Similarly, someone with an income of $20,000 would have paid $3.20.

The average out-of-pocket cost of this tax-based deterrent charge scheme would be significant. The average per capita cost of publicly financed personal health services was $957 in 1982 (Québec, 1984). Someone with an income of only $5,000 would have paid $124.41 out-of-pocket, while for someone with an income of $20,000, the cost would have been $210.54. Of course, people who received services of above-average cost, would have paid even more out-of-pocket. Consider people whose services cost $1500. Someone with an income of only $5,000 would have paid $195.00, while for someone with an income of $20,000, the cost would have been $330.00.

With this tax-based scheme, most people without taxable incomes would pay nothing. But for people with taxable incomes, the scheme would

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[22] The marginal tax rate is the amount of tax one would pay on an additional one dollar of taxable income. The calculations presume that there would be neither a special tax rate for just health benefits nor a minimum payment required of the wealthy with many tax deductions--that health benefits would be treated just like any other type of income.

[23] Although the calculations are based on the assumption of equal uitlization in each income group, lower families probably use more services than higher income families (Boulet and Henderson, 1979; Broyles, et.al., 1983).

## Table VI

## Tax-Based User Charge Proposal for Health Services Some Simulated Effects for Selected Income Groups

## 1982 Data[a]

| | | | Personal Cost of | |
|---|---|---|---|---|
| Total Income | Percent of Taxpayers in Income Bracket | Marginal Tax Rate | Average Office Examination ($14.53) | Average Annual per capita Medicare Cost ($133.77) |
| $ 4,000-5,000 | 3.86% | 13% | $1.89 | $17.39 |
| 9,000-10,000 | 3.71 | 16 | 2.32 | 21.40 |
| 14,000-15,000 | 3.00 | 20 | 2.91 | 26.75 |
| 19,000-20,000 | 2.38 | 22 | 3.20 | 29.43 |
| 24,000-25,000 | 1.75 | 24 | 3.49 | 32.10 |
| 29,000-30,000 | 1.21 | 25 | 3.63 | 33.44 |
| 45,000-50,000 | 0.99 | 28 | 4.07 | 37.46 |
| 75,000-100,000 | 0.38 | 33 | 4.79 | 44.14 |
| 150,000-200,000 | 0.05 | 33 | 4.79 | 44.14 |
| 200,000+ | 0.04 | 33 | 4.79 | 44.14 |

| | Personal Cost of | | | |
|---|---|---|---|---|
| Total Income | Average Health Cost per Capita ($957) | $1500 of Health Services | $2000 of Health Services | Personal Cost of $1,000 Health Services as Percent of Average Income |
| $ 4,000-5,000 | $124.41 | $195 | $260 | 2.89% |
| 9,000-10,000 | 153.12 | 240 | 320 | 1.69 |
| 14,000-15,000 | 191.40 | 300 | 400 | 1.38 |
| 19,000-20,000 | 210.54 | 330 | 440 | 1.13 |
| 24,000-25,000 | 229.68 | 360 | 480 | 0.98 |
| 29,000-30,000 | 239.25 | 375 | 500 | 0.85 |
| 45,000-50,000 | 267.96 | 420 | 560 | 0.59 |
| 75,000-100,000 | 315.81 | 495 | 660 | 0.39 |
| 150,000-200,000 | 315.81 | 495 | 660 | 0.19 |
| 200,000+ | 315.81 | 495 | 660 | 0.11 |

Note:

a. These calculations are based on the user charge proposal of le Groupe de travail sur la révision des fonctions et des organisations gouvernementales(Québec,1986b). They were made using 1982 income tax data (Québec,1986a) and 1982 medicare data ( Québec,1984). See text for explanation of calculations.

be highly regressive. Consider people who received $1,000 worth of publicly financed services, though the specific amount used in this calucaltion is not important. For someone with an income of $5,000, the out-of-pocket cost would be 2.89 percent of his income. On the other hand, for someone with an income of $200,000, the out-of-pocket cost would be only 0.11 percent of his income!

## EXTRABILLING

Unlike deterrent charges, with extrabilling the providers themselves would set the user charges, not the government. The physicians, for example, would be free to set their fees above those paid by the RAMQ, and the patients would have to pay the difference out of their own pockets. Physicians participating in medicare in Quebec have never been allowed to do this, but physicians elsewhere have. Extrabilling by physicians was a central issue in the debate leading-up to the passage of the Canada Health Act by the federal government in 1984.

### Consequences

Extrabilling raises questions not only about the desirability of user charges, but also about the role of the State in the management of the health system. Extrabilling effectively eliminates government control of health spending; if providers want more money than the government is willing to provide, they can extrabill their patients. For a physician it would make it easier to get a higher income. If his hospital also extrabilled, this would also make it easier for him to get access to new equipment and services[24]. Although the purpose of deterrent charges is to reduce health costs, the purpose of extrabilling is to raise them.

It is desirable, however, that the State should continue to have a central role in the management of Quebec's health system--including the management of health spending. The rationale for the State's involvement is discussed in other chapters. In the preceding one, it was argued that in general there are good reasons for the extensive involvement of the State in the management of the system. Then, in the first half of the next chapter, it is argued that it is important for the State to manage the diffusion of new services. Extrabilling, however, could give hospitals the ability to circumvent provincial norms.

But if the State approved the new projects, should extrabilling be used to raise the necessary funds? Rather than have government provide the funds for a new x-ray machine, they could be raised via extrabilling. Indeed, as indicated in Chapter III, some governments have been attracted to user charges in general, and extrabilling in particular, because they are a way to reduce government spending.

There are two substantial problems with using extrabilling as a means of raising revenues. The first is that extrabilling would have the same negative side-effects as deterrent charges. Because of the out-of-pocket costs, some people would probably forego some beneficial health services. Low income families would probably bear a disproportionate share of any reduction in utilization. And, people's out-of-pocket costs would be based on their health status not their ability to pay. Certainly the experiences with extrabilling by physicians in Alberta and Ontario give no reason to think these concerns are ill-founded (Plain, 1984; Stoddart and Woodward, 1980).

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[24] Moreover, as explained in Chapter III, extrabilling is of some interest to governments, too, because it allows them to reduce provincial spending. The problems with this view are also discussed in that Chapter.

The second problem is that extrabilling would create an unstable situation, and forces could easily be set in motion which would lead to a multi-tier health system (Barer et.al.,1979; Evans,1982; Manga,1983; Soderstrom,1983b; Stoddart and Labelle, 1985). In the simpliest scenario, as extrabilling costs rose, people would press government to legalize supplementary private insurance to cover the extrabilling charges. Once such insurance was available, it would be easier for the government to allow extrabilling to grow even more, and physicians would be less concerned about charging even higher fees. Of course, to protect at least some of the poor and aged, a special public program would be set-up, and this would give rise to the multi-tier system. Perhaps physicians would agree not to extrabill the poor and aged. But then these people would be asking for special treatment when they sought care, and treating them would not be as rewarding financially for physicians as treating "paying" customers[25].

Consequently, with extrabilling health costs would be driven up without necessarily improving the health of Quebec residents, and the universality of our current health program would be eliminated. With this loss of universality, low income families would have access neither to the same quality of care nor to services on the same terms and conditions as higher income families. Moreover, access to insured services would become more complicated for people from all walks of life (Soderstrom, 1983b).

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[25] It is more difficult for the State to protect low income families against extrabilling than deterrent charges. The government would have to be willing to reimburse them for any charges they had to pay; no provincial government was willing to do that when physicians were extrabilling. But if the poor had to rely on the good will of the physicians to have the charges reduced or waived, many would probably be hurt. As indicated in the main text, they would have to ask for charity; the waiver would not be a right. Many poor understandably would not ask for the special favor. The physicians, morover, would find such patients less attractive financially, and this might affect the way he treated them (Gabel and Rice, 1985).

## IMPLICATIONS OF CANADA HEALTH ACT

If any user charge scheme were introduced in Quebec for physician or acute care hospital services, the money Quebec receives for health services from the federal government would be reduced because of provisions of the Canada Health Act(Canada, 1984). This Act provides that for every dollar of user fees collected for physician (or acute care hospital) services, the federal cost-sharing payments for physician (or hospital) services will be reduced by one dollar[26]. This provision seems beyond the reach of Quebec health system reformers. Thus, when considering the financial implications of user charges for Quebec residents, the reduction in federal cost-sharing payments must be taken into account.

This federal penalty would force Quebec taxpayers to pay more for health services if a user charge were introduced here; consequently, user charges would increase, not reduce, the tax burden! Even if the cost of health services were significantly reduced by the user charge, the savings would be out-weighed by the reduction in federal payments.

An example will make this clear. Suppose that prior to the user charge health services cost $100. Suppose also that when a user charge equal to 10 percent of costs was introduced, utilization fell and as a result costs fell by $5. Thus, total health costs would be $95 and government spending would be $85.50, the remaining $9.50 being financed by the user charges. But the federal payment would also fall by $9.50, the amount of the user charges, and Quebec taxpayers would have to make-up this lost revenue. Thus, Quebec residents would save the $5 resulting from the reduced health costs and loose $9.50. When the dust settled, they would have an increased tax burden of $4.50[27].

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[26] According to the Act, a user charge means a "Frais d'un service de santé assuré autorisés ou permis par un régime provincial d'assurance-santé mais non payable, soit directement soit indirectement, au titre d'un régime provincial d'assurance-santé..." Note that according to this definition, funds collected via the tax scheme of le Groupe de travail would result in a reduction of federal cost-sharing payments.

## CONCLUSION

Quebec has nothing to gain by introducing user charges. They would raise the cost of health services for Quebec society. With deterrent charges, this higher cost would be the result of the penalties provided for in the Canada Health Act. But it is very doubtful that a deterrent charge would reduce health costs very much even if there were no federal penalty. Neither the evidence from Saskatchewan nor from the RAND study indicates that there would likely be any significant cost reduction[28]. Thus, given that any savings would likely be insignificant---and that there would be some significant negative side-effects--there is no reason for Quebec to start a campaign to repeal the Canada Health Act.

Moreover, if the user charge took the form of extrabilling, there would certainly be higher health spending, without much assurance that there would be a corresponding improvement in health. The increased costs would occur even if there were no Canada Health Act.

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[27] This specific example does not prove the general case. But it is not hard to establish the general proposition that taxes would rise. For example, if in the tax scheme of le Groupe de travail the highest deterrent charge would equal 33 percent of the cost of the service (see Table VI). In this case taxes would go up as long as the elasticity of demand for services (or the elasticity of utilization) was less than 0.75. Judging from all the available empirical evidence, good and bad, the relevant elasticity is much less than that.

[28] The remainder of the empirical literature certainly provides no convincing reason to expect costs to be reduced, either!

There is also good reason to be concerned that user charges would adversely affect some people's health. Certainly the RAND results suggest that they probably would have some negative health effects.

Finally, social equity would also be adversely effected. As the Saskatchewan experience suggests, people from lower income families would likely bear an undue proportion of the burden. Even if there were no utilization effects, the deterrent charge would redistribute income from the sick to the higher income taxpayers, a redistribution of dubious social merit. Moreover, with extrabilling, a two-tier (or multi-tier) health system could develop, destroying the universality of our present program.

# Chapter V
# OTHER FORMS OF PRIVATE FINANCING

## PRIVATE FUNDING FOR INVESTMENTS

Philanthropy and private borrowing are now important sources of financing for new investment projects in Quebec hospitals, as indicated in Chapter II[1]. More private funding in the future seems feasible, too. But would it be a wise thing to do? The wisdom of private finance for new projects involves two separate issues: whether it is the best way to finance socially desirable projects; and, much more importantly, who should make the decisions about which projects are socially desirable, the hospitals or the State.

### The Issues

The first issue concerns only the method of fund raising, not whether more investment spending is now needed. Once government and a hospital have agreed upon a new project, the method of financing must be determined. The government could provide the needed funds, or the hospital could either borrow them or solicit donations. Is there any reason to prefer private over public funding?

Private funding, of course, is now attractive to governments in Quebec and elsewhere. When government finances a project directly, it must raise the necessary funds by raising taxes, reducing its spending on other things, or borrowing. Not surprisingly, none of these options are very attractive politically. The need to do any of them can be avoided--or at least appear to be avoided--by relying on private finance. For example, if the borrowing is done by a hospital rather than by the government, both the government's current deficit and the provincal debt are lower. But, as explained below, this private finance involves more illusion than substance because, whatever the source of the "up front" financing, when the bricks are laid and the equipment installed, the government eventually pays for most of the project's costs.

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[1] Private borrowing now takes the form of loans obtained by the hospitals themselves from financial institutions, though it could also take the form of bonds issued by the hospitals. This private borrowing could be guaranteed by the province and, at least in the case of the bonds, the interest income could be made tax exempt. Furthermore, if the hospitals were investor-owned, they could issue equity (i.e. shares) as well to finance new projects.

The fundamental issue raised by private finance is whether the State or the hospitals should decide which projects to undertake. At present the State approves projects. But, though it is not inevitable, private funding can at least reduce the ability of the State to manage the diffusion of new services. In fact, State control could be eliminated by allowing hospitals to proceed with any project for which they can arrange private financing. This arrangement would certainly appeal to hospitals and physicians who think new services are currently underfunded.

However, even if State approval remains necessary for all new projects, hospitals and physicians are attracted to private financing because it is a way to gain financial independence from the province. At minimum, they correctly see it as a means to proceed with projects that the province would approve, but not finance. But some proponents also see it as a way to circumvent provincial control of new projects.

Both issues are considered here. But evaluating this policy option is difficult because little information is available about the sources of funding that have been used in the past, or about the impact of different sources of funding on investment decisions[2]. Thus, in this evaluation it is only possible to sketch some of the issues that should be considered when deciding about methods of finance.

Financing methods and the availability of services

An important goal of Quebec's health policy is "equity in access", as explained in Chapter III. This requires that people throughout the province be provided with reasonable access to the full array of warranted health services. This, of course, does not require that all services be available in all hospitals. For example, concerns about costs as well as quality of care dictate that open heart surgery be done in only a limited number of hospitals, and that people be referrred to one of these hospitals when they need the service[3].

Thus, at any point in time, there is a "socially optimal" array of services that each hospital should be providing. Public policy with respect to the availablity of services should be directed towards assuring that each hospital is providing this array of services. Private financing and private decision-making about new services are desirable if they facilitate the provision of the appropriate array of services by each Quebec hospital. But would they? This and other questions are explored below.

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[2] It would be useful, for example, to know something about the impact of private funding on provincial funding. In principle, private funding does not "mechanically" reduce government funding because there is no regulation that says provincial funds are automatically reduced by so many cents for every dollar donated by private benefactors. But the availability of private funding does reduce the pressure on the province to provide financing. On the other hand, if a hospital is able to raise the part of the money needed for a project from private sources, the province may be enticed to share part of the cost. Moreover, as already noted, the province eventually does pay off private loans.

[3] This certainly requires that hospitals and physicians co-ordinate their activities, so that everyone has access to important specialized services provided only in a limited number of hospitals. The State must asssure that providers do co-ordinate their activities.

## Public Financing of Private Financing

A new project involves two types of costs. Initially, there are the capital costs for the concrete, steel and flashing lights. Subsequently, there are the operating costs resulting from the utilization of the new service. For example, introducing new X-ray equipment involves, first, the cost of purchasing the equipment and refurbishing the hospital space. Then, operating the equipment will generate hospital costs for the films and the radiology technicians' wages as well as medicare costs for the radiologists' services.

When the capital costs of a project are funded by private donations, the project can be said to be privately financed, unless the province pays for the depreciation of the plant and equipment in subsequent years[4]. Of course, in many cases philanthropy pays only part of the capital costs; some government financing is also necessary. But when the capital costs are funded by hospital borrowing, there really is no private funding because the State is the ultimate source of the finance. When a hospital borrows, a private financial institution does initially provide the funds. But the province eventually repays the loan with interest. The money needed by the hospital to pay-off the loan and for interest payments is provided by the government, as part of its annual grant to pay the hospital's operating costs.

Moreover, the subsequent operating costs of the project are publicly financed, whatever the initial source of the capital funds. Whether those funds were obtained from philanthropy, private borrowing or government grant, the operating costs are financed through Quebec's hospital insurance and medicare programs.

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[4] Currently, the government does not reimburse hospitals for depreciation. Indirectly, even donations are partially publicly financed in the sense that donations provide tax exemptions; the State foregoes some revenues when it encourages philanthropy.

Thus, the distinction between hospital borrowing and government grants, particularly if they would involve provincial borrowing, is largely one of style, not substance. Because of accounting conventions, hospital borrowing means that the government's debt does not increase. Perhaps the government can borrow at lower rates than many hospitals could if they tried to borrow on their own. But this advantage could be overcome if the State guaranteed the hospitals' loans. Moreover, even private donations do not free the State from the need to provide some financing for the projects.

Private financing, then, is essentially public financing in disguise; the financing of approved projects cannot really be privatized. This does not mean, however, that the use of "private" funding is of no consequence. On the negative side, as already indicated, it may reduce the ability of the State to manage the diffusion of new services. The rationale for public management is sketched below. On the positive side, some private funding has two virtures. First, it can facilitate the earlier diffusion of desirable services. Although it is bad policy, as explained in Chapter III, government sometimes refuses to provide "up front" financing for new services, even though it admits the services should be provided. Politicians at present are reluctant to increase goverment spending. Private funds are a way around this undesirable financial obstacle.

Second, some philanthropy is desirable. There is a long tradition of philanthropy for hospitals; some people get great satisfaction from making donations--as well as from the tax breaks such donations provide. Moreover, encouraging private donations may be a very useful way to encourage increased community involvement in hospitals' operations. Thus, there is merit in encouraging philanthropy.

Philanthropy, however, involves problems. One relates to the incentives created for the hospitals. For example, if government budget regulations stipulate that each dollar of donations reduces provincial funding by one dollar, the hospital has less incentive to encourage philanthropy. On the other hand, if the province adopted a mechanical formula stipulating that a hospital raise a certain fraction of the necessary finance via private donations, some hospitals might have trouble raising the necessary funds. There does not seem to be a simple solution for this problem. The government and individual hospitals must negotiate financing arrangements, the role for government financing depending on the needs of the hospital and the availability of philanthropy.

## Need for Public Management

There are at least two reasons why the State should oversee the diffusion of new services. First, if individual hospitals had to arrange all the financing themselves, some may have problems. Some might have trouble borrowing at interest rates as low as the province can obtain; as a result, a government loan guarantee would reduce project costs. In addition, as just noted, the ability of some hospitals to raise money from private donations may not be well correlated with their needs. Some hospitals may be able to attract more funds than they need, while others cannot attract sufficient funds because they are located in a poor region or because private donors prefer to give to the specialized hospitals with the glamorous new technologies rather than to the frontline, but less glamorous hospitals which provide primary hospital services[5].

The second reason is the need for public management of the diffusion of new services. The technological imperative is very strong in modern medicine; individual hospitals and their associated physicians are always keen on adding another service. There are a variety of reasons for physicians' keen interest: the nature of their training; their general inclination to intervene actively in case-management; and their concern about their patients' welfare, their own professional status and their own financial situation. For some of the same reasons, hospital managers are also keenly interested in providing a wide range of up-to-date technology in their institutions. And, of course, the medical technology industry has been constantly pushing physicians and administrators to use their new machines.

The problem is that in the rush to introduce new services, some services are introduced which are ineffective or which yield benefits not warranted by their costs. During the past ten years there has been growing recognition throughout North America that some new technology has been unwarranted, or at least diffused too fast and too widely[6]. The result, many health planners believe, has been unwarranted health spending and adverse effects on some people's health, either directly because the new service itself had negative health effects, or indirectly because time was spent providing the new, but ineffective service to patient A that could have been used to provide effective services to patient B.

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[5] It is also possible to argue that public financing is needed to overcome a "freerider" problem. Philanthropy may result in some individuals paying nothing, even though it is advantageous for them to have the new services available. Such individuals might expect that if they donate nothing, someone else will provide the needed funds. The result could be insufficient funding. Moreover, reliance on the few raises questions of equity.

[6] The relevant literature is large, and growing rapidly. For a good introduction to the issues involved, see Banta and Willems (1981).

The medical profession has played a key role in this process. Consumers and administrators being inherently ignorant of medical matters, the medical profession has shaped our perceptions about what services should be available and how they should be used. This is not to suggest, however, that physicians have the scruples of the proverbial used car salesman; a better comparison is with architects. Montreal's Olympic Stadium fiasco reminds us that if architects are left unconstrainted, they will overdo it.

Thus, the involvement of the State is needed to provide an effective countervailing force to temper the influence of the medical profession. As experience indicates, it is certainly useful to have a second party asking the medical profession what it actually knows about the health effects of a new service[7]. The State must also assess the new service's social value. The State is in a much better position than the medical profession to judge the full cost of a new service, because it is government, not the physician which pays the bills for the service. The political processes may also provide a better indication of social priorities for various services than the judgment of the medical profession.

Of course, the State does make mistakes, occasionally unduely limiting the diffusion of new technology. No decision-maker--public or private--is perfect. Nevertheless, some people jump to the conclusion that private financing should be allowed so that hospitals can circumvent "mistakes". But there is no convincing reason why a hospital and its associated physicians should have such superior wisdom that they would know when the State has erred. Or would any decision of the State contrary to the desires of the hospital always be a "mistake"? One man's wisdom is another man's "mistake"? The need for government involvement in the diffusion of new services arises, afterall, because relying solely on providers' judgments creates problems. A better solution would be to improve public decision-making, an issue discussed in Chapter X.

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[7] The State, of course, is not omniscient. The input of the medical profession into public decision-making is crucial. The extent of the profession's knowledge about the efficacy of health services, however, is shaped by the State, which sponsors much of the necessary research. As explained in Chapter X, without State sponsorship there would be insufficient technology assessment.

A danger with private funding, as already indicated, is that access to such funds may give hospitals a means of circumventing provincial policies with respect to the availability of services. Obviously, if the government were the sole source of funding, then it could assure that the provincial norms were observed. But, when hospitals can get funding elsewhere, it is easier for them to get around the norms, in whole or in part. If a hospital administrator can find the needed finance privately to develop a new service and if he believes that the province will finance the subsequent operating costs of the service, then he will find it much easier to yield to the pressure from the hospital's medical staff to introduce the service. Once the hospital has financed and installed the concrete and chrome, it will then be very difficult politically for the government to tell the hospital that it cannot use the new facilities or to deny it the necessary operating funds.

For example, a recent Ontario study of the diffusion of the CAT scanner in that province demonstrates that some Ontario hospitals have been able to install more of these expensive machines than the Ministry of Health wanted. An important reason why they were able to do this is that they could obtain the necessary acquisition funds privately (Deber and Leatt, 1986)[8].

## Conclusion

The need for State management of the diffusion of new services is not an argument against some private funding for new hospital investments, however. But it does imply that the use of private funding must be properly structured so that it does not become a means by which hospitals can circumvent provincial policies[9].

For approved projects, however, private funding is acceptable. There being no real difference between private and public borrowing, the only substantive issue is the role of philanthropy. Encouraging a hospital to obtain donations from the community may be one way to build community interest in the operation of the hospital. But there are some constraints on the extent to which it is wise to rely on philanthropy. First, as has been stressed, some hospitals may not be able to generate sufficient donations. In such cases the State must assure that the hospital has sufficient capital funding that it can provide its appropriate array of services. Second, fund raising has its costs. For example, it can divert staff time from patient care. At some point it becomes more efficient for the staff to focus on its primary responsibilities and for the province to finance new services.

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[8] Although the situations are not identical, the problems American health officials have had trying to control the diffusion of new services using the "Certificate of Need" approach is additional evidence that problems arise when the sources of investment decisions and the sources of funding are separate (Salkever and Bice, 1976)

[9] There are certainly several things that the State can do to enforce its policies, besides writing laws and regulations requiring State approval for new capital projects. First, it should have well-developed, defensible and understandable policies regarding the diffusion of new services. The Ontario Ministry of Health did not have much of a policy with respect to the diffusion of CAT scanners, which further complicated its efforts to control their spread. Second, provincial loan guarantees obviously should be limited to those projects which have provincial approval. Third, provincial financial support for the capital and operating costs of a project should be contingent on provincial approval of the project. This latter requirement is easier to defend publicly to the extent that the province has formulated a good policy relating to the diffusion of the new service.

## THE SALE OF "EXTRA" SERVICES

Another private source of additional funds would be the expansion of hospitals' current commercial activities. Hospitals now provide and charge for a wide variety of "extra" services, thereby generating some revenue for themselves. It would certainly be feasible for hospitals to expand these activities. For example, with respect to their patients, they now rent TVs and levy extra charges of semi-private and private rooms. They could also charge for "deluxe" meals. In addition, they frequently charge visitors for use of the hospital's parking lots, and operate gift shops and food services for them, too. They could also provide accommodation for family members who want to remain close to someone hospitalized. Moreover, they charge for parking and food services for staff.

Finally, hospital managers do some outside consulting and, hospitals sell some services (e.g. laboratory, computing and dietary) to other hospitals. Hospitals could also sell a variety services to people in the community[10]. They could lease extra space to community groups (e.g. day care centers) and research groups, as well.

Although hospitals have long raised some revenue from such sources, the amounts involved have been small, as indicated in chapter II. It is feasible, however, for hospitals to expand their sales of "extra" services. Ontario has done more than any province to exploit this revenue source; its

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[10] An Ontario hospital has recently tried selling oxygen to people who needed to have oxygen available at home and offering a special course for people who wanted to stop smoking (Quigley, 1985).

BOND program encourages Ontario hospitals to generate more revenue from such sales.

Unfortunately, there is very little literature relating to either the consequences of the BOND program for the performance of Ontario's hospitals, or the impact of commercial activities generally on hospital performance. As a result, it is only possible here to sketch some of the issues which should be considered when deciding whether to expand this form of private finance. The focus here is on the wisdom of pushing sales of extra goods and services, though some of these comments--as well as those in chapter VII--are also relevant to the wisdom of pushing outside consulting.

## Use of the "Profits"

By expanding the sales of such services hospitals could obtain additional funds for various "special projects". Such projects could improve patient care services and make the hospital a better place to work[11]. But the ability of individual hospitals to raise revenues this way--and consequently to finance "extra projects"--may vary. A hospital may have little space for parking lots or shops, or most of its patients may be from low income groups. Thus, the social utility of the "special projects" may not be well correlated with the availability of profits from these sales. This makes it difficult to stipulate that important projects must be self-financed by the hospital from commercial activities.

For example, the profits from the BOND program are to be used for the replacement of existing plant and equipment as well as new projects. But can such sales provide all hospitals with adequate resources for these purposes? Should the ability to sell hospital sweatshirts in the gift shop determine the ability of a hospital to replace important, but out-moded X-ray equipment?

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[11] The discussion in the first half of this chapter implies that if the profits are used to introduce new services, government approval of the new services would be needed before the concrete is poured.

What sort of a pricing policy should a hospital use? Should it set price so as to maximize profits? What allowance should be made for the therapeutic value of some of the services? For example, TV distracts many patients from their afflictions, and having family close-by may help some patients. Thus, to some extent, encouraging TV usage and developing family accommodations may help make the hospital function more smoothly as well as help patients cope better with their situations. Maximizing profits from TV rentals and family accommodations, however, would negatively affect the use of such services.

What effect should the profits from such sales have on the annual provincial operating grant? At present, with one exception, the profits reduce the provincial grant dollar-for-dollar, unless there is some "creative accounting". This certainly does not offer much incentive to a hospital to develop these sales. The one exception is the revenue from semi-private and private rooms, which is divided equally between the hospital, the regional council and the province.

## Some Potential Problems

Increasing commercial activities could have mixed effects on patient care. As already noted, the profits could be used to fund some special projects of benefit to patients. But, exploiting some sources of revenue could create significant negative effects. Some might be inconsistent with the primary mission of the hospital, patient care. A good example is the suggestion that hospitals provide a "standard" meal to all patients without charge and a "deluxe" meal at some cost to any patient who opted for it. A red carnation and some Dom Pérignon, my dear? But would such a scheme be in good taste? While the hospital is supposed to provide all patients decent meals, it would have a financial incentive to skimp on the "standard" meal in order to stimulate interest in the "deluxe" meal. Whatever the reality, the actual performance of the food service would be viewed in this light. It has been some time since a Quebec hospital received four stars for fine cuisine. If Quebec hospitals were making money on "deluxe" meals, they would certainly not be encouraged to provide tasty "standard" meals.

There could also be other effects on the quality of care and costs, some good, some bad. Efforts to increase sales could increase the efficiency with which certain services are produced. In order to win a contract to supply computer services to other hospitals, the manager of the computer center would have some incentive to eliminate waste. Managers involved in outside consulting might also discover better ways to do certain things.

At the same time, revenue-generating activities may distract managers and staff from the hospital's primary mission: patient care. Extra sales take some of their time and give them added headaches, particularly adventuresome schemes where the hospital has competitors (Quigley, 1985). Staff may be under some pressure to generate extra revenues, and this could adversely affect their morale. An important criteria for evaluating a manager's performance, for example, could easily become the profits he generated from outside sales. It is not too surprising, then, that in a recent survey of large Canadian hospitals that the idea of developing commercial activities received much more support from senior managers than from middle management or from employees (Stock and Lefray, 1986).

## Conclusion

The sales of "extra" services at reasonable prices should be modestly encouraged, but it should not pushed. Certainly, government budgetary procedures should be changed to give the hospitals some incentive to generate more sales. But the significance of this activity should not be blown out of proportion. It could provide a little money for some special projects. The primary purpose of a hospital is patient care, however, not selling monogramed beermugs and t-shirts in the main lobby. Certainly basic patient care services, such as food services, should not be commercialized. Attention must also be given to the impact of such activities on the hospital staff.

# Chapter VI
# INVESTOR-OWNED HOSPITALS

The ownership of some Quebec hospitals could be privatized if groups of private investors bought them from their current nonprofit owners[1]. Proponents argue that this is one way to improve the efficiency of the hospital sector. In this chapter their arguments and the available empirical evidence are reviewed. Then the role of investor-owned hospitals in Quebec is discussed.

## OWNERSHIP AND EFFICIENCY

### Organizational Differences

The central issue here is the effect of ownership on the performance of a Quebec hospital. But it is important to bear in mind that the hospital's performance also depends on the outcome of its interaction with its physicians and the State--each pursuing its own particular goals. The State is concerned about the well-being of Quebec society, and the physicians, about their patients' and their own welfare. The nonprofit hospital is concerned about community service.

With an investor-owned hospital, however, the objective of the organization is to make profits, and community service is a by-product of that quest. Consequently, the investor-owned hospital may perform differently for a variety of reasons. First, such a hospital may use different decision-making criteria because it has financial concerns that are somewhat different from those of the nonprofit hospital. It has a financial incentive to find the least cost-method of producing each type of service and the most profitable mix and quantity of services. The nonprofit hospital also has good reason to be concerned about its costs, however; as explained below, the biggest differences between the two hospitals probably relates to decisions about the mix and quantity of services.

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[1] What the current owners would do with the proceeds is unclear. Perhaps they could give them to other nonprofit hospitals.

Besides using different decision-making criteria, it is often argued that the investor owned hospital in its quest for profits does several other things differently. The hospital has a financial incentive to develop better quality management and management methods, it is argued, than are available in many nonprofit hospitals. Frequent reference is made, for example, to the claim that investor-owned hospitals use better management information systems.

Almost all of the discussion of investor-owned hospital relates to the situation in the U.S.. Many of these American hospitals are owned by an investor-owned chains, such as the Hospital Corporation of America, which owns 200 hospitals, and American Medical International, which has 115 hospitals (Hoy and Gray, 1986). As a result, the alleged advantages of investor ownership get mixed together with the advantages of chains. For example, it is argued that investor-owned hospitals can exploit economies of scale through buying in bulk and having a stable of expert consultants. Economies of scale, of course, would be available to any chain, investor-owned or nonprofit.

Again reflecting the situation in the U.S., it is also claimed that investor-owned hospitals have better access to capital markets. In the U.S. in recent years government financing and philanthropy have largely disappeared, so hospitals have had to turn to financial markets for investment finance. It is plausible that investor-owned hospitals, particularly those in a chain, could obtain more favorable terms when they borrow than an independent, nonprofit hospital. But not necessarily more favorable terms than government could obtain.

## The Cost of Services

Certainly it is possible, as the proponents of investor-owned hospitals argue, that the difference in ownership does create significantly different financial incentives, which result in investor-owned hospitals producing at lower cost particular services (e.g. food, maintenance, nursing, intensive care, library services, etc.). But this issue is more complicated than the proponents sometimes indicate. Critics of investor-ownership argue, for example, that if such hospitals do have lower costs, they do it by making unwarranted sacrifices in the quality of patient-care. Moreover, the critics continue, it is not self-evident that investor-owned hospitals do produce services of given quality at significantly lower cost.

Lowering costs can be a good thing; but it also can be a bad thing. It all depends on what is sacrificed. Critics are concerned that investor-owned hospitals sacrifice too much. They fear that in its quest for profits an investor-owned hospital not only eliminates the excess soap used in the dishwashing machines, but also reduces nursing staff and thereby the quality of patient care. Certainly the concern about profits creates a financial incentive at an investor-owned hospital to sacrifice some of the quality of a particular service that would not exist at a nonprofit hospital, given its concern about community service. This argument, of course, does not presume that the quality of care currently provided in all Quebec hospitals is splendid. It only presumes that in its quest for lower costs, an investor-owned hospital would be willing to sacrifice more quality than a nonprofit hospital would[2].

However, the distinction between the cost concerns of the two types of hospitals is not as sharp as some simple analysis suggests. It is usually stressed that an investor-owned hospital has a financial incentive to produce each service at least cost, but it is seldom noted that a nonprofit, lay-operated hospital is also concerned about its operating costs. Each hospital has reason to be concerned about its "residual", the difference between its revenues and costs. This residual is important to the investor-owned hospital because it is the hospital's profit. But the residual is important to the nonprofit hospital as well because, stated simply, it is an important source of funding for new projects for the hospital. Because both hospitals benefit from a large residual, both should be concerned about their costs; for a given revenue, lower costs mean a higher residual. Thus, in many of the economists' models of a nonprofit hospital that have been proposed during the past 20 years, the hospital is viewed as minimizing the cost of producing a particular set of services (Jacobs,1974).

To develop this point further, consider the performance of Health Maintenance Organizations (HMOs). As explained in Chapter IX, most health planners have been very impressed by the efficiency with which many HMOs provide health services. It is interesting, then, that HMOs have been almost exclusively nonprofit organizations, at least until very recently (Institute of Medicine, 1986). This warns that nonprofit organizations should not necessarily be equated with grossly inefficient organizations mis-managed by a gang of bungling bureaucrats[3].

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[2] It is a straight-forward exercise to show analytically that, when contemplating reducing nursing staff, the nonprofit hospital would consider the cost-savings, but that it would give more weight to any adverse effects on the patients than the investor-owned hospital would.

Similarly, there is no convincing reason to think that investor-owned hospitals--anymore than Bombardier or la Banque Nationale--function like the competitve, profit-maximizing firms that dwell in economics textbooks. Indeed, if one reads further into the textbooks, one often finds other possible forms of firm behavior described, forms which do not imply cost-minimization (Leibenstein, 1980; Scherer, 1986).

The distinction between the two types of hospitals becomes even more blurred when one recognizes that the environment in which a hospital functions may be at least as important a determinant of its efficiency as its orientation towards profits. Consider two examples. First, if hospitals were reimbursed on a cost-plus basis, there is no incentive for either the investor-owned or nonprofit hospitals to minimize their costs. In fact, at least until recently this was the situation in the U.S., where medicare and private insurance companies reimbursed hospitals on a cost-plus basis. Thus, the aledged inefficiency of U.S. hospitals may have more to do with reimbursement methods than with their profit orientation.

Secondly, if hospitals have been squeezed financially by their reimbursement agencies for a prolonged period, the quest for survival could have forced either investor-owned or nonprofit hospitals to produce services as cheaply as possible. In such a case, changing ownership would not result in greater efficiency. In fact, Quebec's nonprofit hospitals have been squeezed for 10 years.

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[3] Before jumping to the conclusion that investor-own HMOs would be even more efficient, it is worth noting that in the one comparative study of investor-owned and nonproft HMOs, it was found that the latter had lower average costs (Schlesinger et.al.,1986).

To test empirically the proposition that investor-owned hospitals produce services at lower cost, it would be desirable to contrast the costs of particular services at a group of investor-owned hospitals and at a group of nonprofit hospitals (with all either belonging to chains of the same size or being independent). Unfortunately researchers have not made such comparisons because the necessary data are not available. Instead, the average costs per admission (or average cost per patient day) are compared. This is reasonable if comparable patients are being treated in the two groups of hospitals.

Of course, it is not sufficient to determine that investor-owned hospitals have lower cost. It is equally important to compare the quality of care to see if the investor-owned hospitals do in fact provide services of lower quality.

Moreover, when thinking about the social utility of investor-owned hospitals, consideration must also be given to the extent of inefficiency in Quebec hospitals. It is not sufficient to show that investor-owned hospitals are systematically more efficient in order to justify a policy of encouraging their development. The existing inefficiency must also be sufficiently great that its elimination would provide an "adequate" return on the owners' investment plus a significant savings for Quebec society.

## The Mix of Services

Investor-owned hospitals probably make different case-mix and case-management decisions than nonprofit hospitals, however, because of the differences in their objectives. The investor-owned hospitals have a greater incentive to make decisions with an eye on the profit consequences.

Although nonprofit hospitals are concerned about their "residual" as well, they are also concerned about "community service", their raison d'être[4].

The profitability of various cases and ways of managing them depends on both revenue and cost considerations. For present purposes, it is useful to focus on the investor-owned hospital's reimbursement structure--the formula that determines the revenue the hospital receives for each particular case. Certainly the reimbursement structure will effect both case-mix and case-management decisons.

If the reimbursement structure is such that providing effective services is not rewarded, effective services will be provided less frequently than otherwise. Similarly, if the provision of ineffective services is rewarded, they will be provided more frequently than otherwise. Moreover, if it is possible for a hospital to manipulate its reimbursement rates, it will do so with it eye on its profits.

Actually, the impact of reimbursement structures on hospital behavior is similar to the effect of reimbursement structures on physician behavior. For example, if a hospital's revenue increases as it provides more services, then it will have an incentive to provide more services than otherwise. This situation is comparable to that of a physician under fee-for-service. Similarly, if revenue increases with the number of cases admitted, the hospital would probably treat more cases than it would if revenue were fixed.

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[4] The key point is that the two organizations have different objectives, and that this difference is of some consequence for decisions relating to case-mix and case-management. The proponents of investor-ownership claim that financial incentives are important, so it seems reasonable to argue here that such hosptials have an incentive to make decisions with an eye on the profit consequences. Exactly what the goals are of nonprofit hospitals has long been debated. Here the objective of "community service" can be interpreted in a broad or a narrow sense, as long as there is a perceived difference between this type of organization and an investor-owned hospital.

Of course, hospital behavior is more complicated than simple economic reasoning suggests. Attention must also be given to the admission and care management decisions of the medical staff. Whatever the goal of the hospital, the service mix is influenced by physicians' behavior. The profit orientation of the hospital does not necessarily alter the fact that the physicians, who are traditionally not hospital employees, play an important, independent role in shaping the utilization of hospital services[5]. At least so far, in the American investor-owned hospitals the role of the physician has not been profoundly changed (Alexander et.al.,1986; Musacchio et.al.,1986). This independent role of the physicians may soften the effects of the profit incentives on case-mix and case-management decisions.

But hospital mangement would still have some influence on physicians' decisions. It certainly could structure their work environment so as to encourage them to behave differently. For example, if management wanted to increase laboratory testing because it was profitable, management could expand the facilites and encourage physicians to make use of the profitable testing methods available. Alternatively, if it wanted to reduce the use of unprofitable radiotherapy services, it could reduce (or even eliminate) the resources available to provide those services, and discourage physicians from using what services were available. Management could also alter the composition of the hospital's medical staff in order to get a group of physicians whose behavior in more compatible with the interests of the investors.

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[5] Two points: First, if investor owned hospitals were allowed in Quebec, should physicians be allowed to own hospitals? Hospital ownership would superimpose another conflict of interest situation on the one that currently exists with the fee-for-service remuneration method. Second, if corporate interests really dominated the hospital, the hospital could be transformed from the physicians' workshop into the physicians' workplace. Physicians could become employees of the hospital corporation. This change in status could result in their practice patterns being much more dominated by the corporation's profit concerns than is suggested in the text.

Consequently, investor-ownership could yield different case-mix and case-management decisions. If the services they provided were of greater benefit (net of costs) to society, the development of investor-owned hospitals would enhance efficiency. But there is no guarantee that this would be the result of investor-ownership *per se*. Much depends on the reimbursement structure confronting them. It is beyond the scope of this analysis to delve into this issue in much greater detail. But it is probably a reasonable conjecture that current reimbursement structures in the U.S. and in Quebec do not provide the incentives that would be needed to assure that investor-owned hospitals would provide a more socially desirable mix of services.

Certainly the critics of investor-owned hospitals in the U.S. are very concerned that such hospitals do not opt for a socially desirable mix of services. These critics suspect that the quality of care may be lower in investor-owned than in nonprofit hospitals. The investor-owned hospitals certainly have a financial incentive to reduce quality when making case-management decisions, *ceteris paribus*, that the nonprofit hospitals do not have. This does not presume, of course, that the quality of care now provided is necessarily exceptionally high, or that higher quality is always worth the additional cost. (As already indicated, the critics frequently claim as well that investor-owned hospitals *ceteris paribus* would reduce the quality of specific services, too.)

There is also much concern that such hospitals neglect poor patients who cannot pay or whose insurance (i.e. the Americans' Medicaid program) pays low rates, and that they prefer to treat low cost cases and avoid high cost cases. As a result, the poor and people with costly health problems must go elsewhere for treatment. In short, critics claim that investor-owned hospitals engage in "cream skimming". One consequence of this, of course, is that the investor-owned hospitals make profits by pushing-up costs elsewhere in the system.

In Quebec, hospitals each year receive a fixed sum of money, determined at the beginning of the fiscal year. To get some idea of how an investor-owned hospital would operate under this reimbursement structure, consider a very simple vision of the behavior of such a hospital confronted with a fixed budget. In this situation the hospital would maximize profits by minimizing its costs, though of course it would be constrained by the standards of patient care of its physicians and other health professionals. To treat any particular case, the hospital would have an financial incentive to use the least costly mix of services possible. It would also have an incentive to sacrifice some quality *ceteris paribus* in order to increase profits. Finally, the hospital would have an incentive to keep the number of cases as low as possible, and to engage in "cream skimming"--to avoid unprofitable high cost intensive care cases and to encourage high profit low cost cases.

Of course, reality is more complex than this simple analysis suggests. One important reason is that the hospital's current performance affects its budget for the next year. If it were too aggressive in reducing its costs by trimming services and made very high profits, its next budget would likely be reduced. Moreover, if more cases would increase its profits, the hospital would then encourage more admissions this year, hoping that next year it could get a bigger budget.

Could Quebec avoid some of these adverse effects by using a different reimbursement structure for investor-owned hospitals? It probably could raise the quality of care by paying more, particularly if it paid the hospital according to the services provided. But this would have the same disadvantages that fee-for-service has for physicians. The government might avoid "cream-skimming" by making the hospital responsible for all hospital costs of a prescribed group of people, whatever hospital provided them. But this begins to convert the hospital into an HMO. And if that is what must be done to obtain reasonable performance, why bother at all with investor-owned hospitals? It would be preferable to develop complete HMOs, as suggested in Chapter IX.

A key implication of this analysis of service mix is that investor-owned hospitals need not be lower cost operations than nonprofit hospitals. Much depends on the nature of the reimbursement structure. Suppose the standard sterotype were true, that investor-owned hospitals did produce each service at lower cost than nonprofit hospitals. These savings could be offset, however, if the hospitals in their quest for profits also admitted more cases, had more expensive case-mixes, used more expensive mixes of services to treat its patients, or charged higher rates for services rendered. Whether investor-owned hospitals would pursue such cost-augmenting strategies would depend on the nature of the prevailing reimbursement structure.

## EMPIRICAL EVIDENCE

The available empirical evidence is based entirely on the American experiences with investor-owned hospitals. Unlike Canada, the U.S. has a significant number of investor-owned, acute care hospitals[6], and there has been much interest in the effect of ownership on hospital performance in the U.S.. The Americans also have many investor-owned nursing homes; the empirical evidence regarding the effects of ownership on nursing home performance is reviewed briefly in the accompanying appendix.

Although a substantial number of researchers have studied the effect of ownership on hospital performance, they have generated very little evidence regarding the effects of ownership on quality of care and patient selection. Their primary interest has been on the cost and revenue effects of investor-owned hospitals. Although these researchers have used a variety of data sources and methods of analysis and the quality of their work varies, there is some consistency in their findings. Thus, a detailed, article-by-article review of the literature is not necessary[7].

### Cost and Revenue Effects

The recent results of Watt et.al. (1986a) provides a good illustration of the research that has been done. These researchers analyzed data for 80 matched pairs of acute care general hospitals in eight states for the year 1980. The investor-owned hospitals all belonged to investor-owned hospital chains; the nonprofit ones included 71 voluntary and hospital-district facilities and 9 owned by a city or county.

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[6] In 1983 13 percent of the American acute care hospitals were investor-owned. These hospitals contained 10 percent of the available acute care beds. Their importance has grown, too. In 1975 these hospitals were only 6 percent of all the hospitals and they contained only 5 percent of the available beds (Institute of Medicine, 1986).

[7] Good article-by-article reviews of the literature are provided by Stoddart and Labelle (1985), Ermann and Gabel (1986), and the Institute of Medicine (1986), pp. 74-96.

Two important results emerge from this research: first, there was little difference in the costs per case between the two groups of hospitals; and second, the investor-owned hospitals charged significantly higher rates. Watt et.al. found that the in-patient costs per admission (case-mix adjusted) were 5 percent higher among the investor-owned hospitals, but the in-patient charges per admission were 22 percent higher. Even after adjusting for the profit taxes which only the investor-owned hospitals must pay, their in-patient charges remained higher.

These results imply that the investor-owned hospitals made their profits by charging higher rates, not by operating with lower costs. Most other researchers have come to the same conclusion (Ermann and Gabel, 1986). This result is not surprising. The American Medicare program and some private insurance companies provide a special supplementary "return-on-equity" payment only to the investor-owned hospitals. Whether these hospitals are also more aggressive in selling higher rates cannot be determined from the available evidence.

Watt et.al. also provide some interesting detail about the operation of the investor-owned hospitals. For example, these hospitals had slightly higher costs for most types of services, from "hotel services" to radiology services. Much of the higher costs were related to higher administration and depreciation expenses. The former may stem from the special fees that the hospitals paid to their home offices. And the latter stems from the fact that the investor-owned hospitals either had newer facilities, or, in the case of those that had recently been bought by a chain, the value of their assets had been revalued upwards.

The investor-owned hospitals did have lower plant operation costs per patient day, however. But this difference may be related more to the fact that these hospitals were significantly smaller physically (as measured by square feet per bed) than to greater efficiency in providing the services. The investor-owned hospitals also used significantly fewer full-time equivalent workers per patient day. But they tended to pay higher salaries, so their labour costs per patient day were not significantly different from those of the nonprofit hospitals.

Another way to analyze the effects of investor-owned hospitals is by examining what happens when hospitals change ownership. Brown and Klosterman(1986) studied 27 Florida hospitals which changed ownership between 1979 and 1982. Relative to other Florida hospitals, these hospitals were in a more precarious financial situation prior to being taken-over. After the change in ownership there was some improvement in their profit margins relative to those of other hospitals. But the improvement was not the result of reduced costs. Indeed, these hospitals had relatively large increases in their cost per admission -and even larger increases in revenues per admission.

Thus, the American evidence implies that investor-owned hospitals do not have lower costs than the nonprofit hospitals. However, all of these researchers used data gathered in the 1970s and early 1980s. This was an era when hospitals were generally reimbursed on a cost-plus basis. Moreover, the investor-owned hospitals tended to locate in states with less restrictive hospital regulatory environments[8]. Consequently, as so many observers have noted, this was not a reimbursement structure which created much incentive for hospitals--investor-owned or nonprofit--to be concerned about costs.

The reimbursement structure has changed in the U.S. Medicare now pays a fixed amount of money per admission, the exact amount depending on the primary diagnosis of the patient[9]. Moreover, there are growing competitive pressures on American hospitals to contain their costs. Employers are increasingly concerned about high health insurance costs, and the HMOs are growing, at least in a few localities. In this environment some observers have speculated that the superiority of the investor-owned hospitals should at last become evident as these hospitals cut their costs in their quest of more profits. That is certainly a logical possibility. But it is at least equally plausible, as explained earlier, that both types are concerned about their costs, and that their cost performance will continue to be very similar. It will be several years, however, before researchers will be able to determine whether the two types of hospitals are now performing differently. But available evidence certainly makes it clear that the investor-owned hospitals are not inherently less costly.

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[8] California, Texas, Florida, Tennessee and Georgia.

[9] This is reimbursement by Diagnostic-Related Groups (DRGs).

## Patient Selection and Quality

Unfortunately, there is much less information available relating to the effects of ownership on patient selection and quality[10]. Most of what is available relates to patient selection, and it supports a tentative conclusion that ownership does have some effects on patient selection, both in terms of case-mix and the class of people admitted. Watt et.al.(1986a) reports that investor-owned chain operated hospitals and the nonprofit hospitals had very similar medicare case-mix indices. They also report that there was no difference in the ratios of intensive care days to total inpatient days. But they do suggest that the investor-owned hospitals provided less outpatient care. Moreover, Watt et.al. (1986b), using 1980 data for 4,491 general acute care hospitals, report that the independent investor-owned hospitals had a slightly less complex casemix and did less inpatient surgery. They also report that the investor-owned hospitals--chain and independent--provided significantly fewer obstetric services--an activity long viewed as "unprofitable" for any type of hospital.

There also appears to be some effects on the class of people admitted. Watt et.al.(1986a), like a number of other researchers, report that ownership had little effect on the willingness of the hospital to admit older patients on medicare or poor patients on medicaid. But a number of researchers report finding that investor-owned hospitals do avoid charity cases. Certainly there is much anecdotal evidence that they avoid patients without insurance (Wrenn, 1985)[11]. In 1983 the value of uncompensated care was only 3.1 percent of gross patient revenues of investor-owned hospitals, 4.2 percent for nonprofit hospitals and 11.5 percent for government hospitals[12]. In the case of the 27 Florida hospitals which changed ownership, one of the ways that the hospitals bought by private investors increased their profit margins was by reducing their charity cases (Brown and Klosterman, 1986).

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[10] This is not because these effects are presumed unimportant in the US. Rather, such analysis requires much more complicated research. It is not difficult to analyze the effect of ownership on costs because the necessary cost data are readily available. But before the researcher can analyze the effects of ownership on quality, he must generate meaningful information about quality, which is a difficult task.

There is almost no evidence of any consequence relating to the quality of care. What little is available suggests that there are no obvious "structural" differences between investor-owned and nonprofit hospitals with respect to things like prevalence of hospital accreditation, board certification of staff physicians, and the amount of nursing personnel (Longo, 1986). In the one study of mortality rates among Medicare patients who had elective surgery, mortality appeared unrelated to ownership (Gaumer, 1986).

Unfortunately, this American literature is of limited use in assessing the likely consequences of developing investor-owned hospitals in Quebec. No researcher has sought to test directly the proposition that investor-owned hospitals engage in "cream skimming". Moreover, at the time the data used in this research were gathered, most U.S. hospitals had considerable latitude in setting their rates. As a result, the investor-owned hospitals did not have a great incentive to be very selective about patients admitted or to cut quality. In the Quebec, however, hospitals are reimbursed differently, using fixed budgets, and they have eliminated a lot of waste during the past 10 years of budgetary constraint. Consequently, an investor-owned hospital here in its quest for profits would have a much greater financial incentive to be selective about its case-mix and to sacrifice some quality.

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[11] Another reason they have fewer charity cases is that they are frequently located in suburban areas where there are few charity cases in the first place.

[12] Institute of Medicine (1986), p 102.

Nevertheless, there is an important lesson for Quebec in the U.S. results: it would be naive to think that investor-owned hospitals were unresponsive to the differences in profitability of various types of patients. Given the reimbursement structure in the 1970s and early 1980s in the U.S., there was one group of people that the American investor-owned hospitals did have an incentive to avoid: the charity patients. It is striking, then, that in comparison with the nonprofit hospitals the investor-owned hospitals apparently did have fewer charity cases. Of course, with public financing of hospital services, there are no charity cases in Quebec. But what this result does indicate is that investor-owned hospitals do heed the financial incentives and select their patients with an eye on their profits. In Quebec the search for a profitable case-mix would result in "cream-skimming".

## Committee on Implications of For-Profit Enterprise in Health Care

In the U.S. the Committee on Implications of For-Profit Enterprise in Health Care has just completed a review of the literature and the substantial new research which it commissioned. Its appraisal of investor ownership certainly warrants serious attention (Institute of Medicine, 1986). The Committee was composed of 22 academics and nonacademics with many years of involvement with the American health system. This Committee was sponsored by the prestigeous National Academy of Sciences and its Institute of Medicine plus the National Academy of Engineering.

The Committee has concluded:

> "... *that available evidence on differences between for-profit and not-for-profit health care organizations is not sufficient to justify a recommendation that investor ownership of health care organizations be either opposed or supported by public policy.* ...However, the for-profit mode cannot now be seen as a possible solution to such important public policy issues as control of health care costs, ensuring access to care or maintaining quality of care.[13]"

Moreover, seven members of the committee appended a supplementary statement, in which they observed

> "In our opinion the major finding of this report is that the investor-owned hospital chains have so far demonstrated no advantages for the public interest over their not-for profit competitors. ...A substantial increase in the for-profit sector's share of the health system could 1) put further pressure on hospitals, voluntary organizations and other facilities that provide needed but less profitable services; 2) create powerful centers of influence to affect public policy; and 3) increase the drift of the health care system toward commercialism and away from medicine's service orientation. These concerns reinforce the implication of the committee's report that we would have little to gain, and possibly much to lose, if for-profit corporations came to dominate our health care system.[14]"

## ROLE OF INVESTOR-OWNED HOSPITALS IN QUEBEC

Thus, there is certainly little evidence suggesting that changing the profit orientation of Quebec's hospitals would significantly improve the performance of Quebec's acute care hospital system. It is important to recognize that there does not now exist a mass of theoretical and empirical evidence demonstrating that investor-owned hospitals are superior. Indeed, the available evidence indicates that such hospitals are not inherently more efficient than nonprofit hospitals, even in providing food and nursing services. This should make one wary of privatizing Quebec hospitals at this time. What evidence is available suggests no efficiency gains would result, and it hints that barriers to access for some patients might result.

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[13] Institute of Medicine (1986), pp. 191.

[14] ibid, pp. 205.

## Relevance of the American Evidence

Of course, the environment in which the American hospitals were operating was different from that in which the Quebec hospitals now operate. First, Quebec hospitals are reimbursed using prospective budgetting while U.S. hospitals were reimbursed on a cost-plus basis. Would the ownership effects be different under prospective budgetting? Analytically, as explained earlier, there is no compelling reason to expect that profit-orientation would have a substantially different impact on the hospitals' concerns about their costs under prospective budgetting than with cost-plus reimbursement. Both investor-owned and nonprofit hospitals have a financial incentive to minimize their costs of producing particular services of a particular quality. However, the investor-owned hospital would have a greater incentive to push its cost reductions further, sacrificing some quality of care and engaging in some "cream-skimming"-- results which would be of questionable social value[15].

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[15] Investor-owned hospitals would certainly have a stronger financial incentive to pressure government to allow them to cut their costs in ways that would not benefit Quebec society and to provide them with additional revenue. Suppose a reduction in hospital beds were warranted in the Montreal area. Would government be more reluctant to cut beds at the investor-owned hospitals than the nonprofit hospitals, because it was concerned about the adverse effects it would have on the former hospitals' profits?

Moreover, unlike their American counterparts, Quebec hospitals have been under substantial budgetary pressures for the past 10 years. Hospitals here have had considerably more incentive to reduce their costs of providing services, and to reduce the number of ineffective services. Thus, it is not obvious that even if investor-owned hospitals were more efficient in the U.S. that they would significantly enhance efficiency here. Would they save enough that Quebec society would also gain? Is the inefficiency currently so great that investor-owned hospitals would save enough money that they could not only make desired profits, but also provide the rest of Quebec society with a saving large enough to warrant making privatization of hospitals a significant thrust of Quebec's health policy during the next five years? How inefficient are Quebec hospitals now? There has been much talk about inefficiency, but there has been surprisingly little evidence about its magnitude forthcoming from the Quebec research community.

## Different Incentives vs Different Management

This is not to say that ways could not be found to improve efficiency in many Quebec hospitals. Any compentent hospital manager or management consultant could probably find some ways to reduce costs. But it would be a mistake to jump from this observation to the conclusion that privatization was necessary. Even if all hospitals had been privatized, competent managers or management consultants would probably still be able to find ways to reduce costs. There is certainly no evidence from the private sector indicating that such outside observers could not find ways now to reduce costs of most private firms.

Of course, changing the profit orientation of a few hospitals might result in their performing better than they now do. Whether the hospitals are investor-owned or nonprofit, there will be variation in the efficiency with which they provide particular services. Thus, the average investor-owned hospital might well perform better than the least efficient nonprofit Quebec hospital today. But this does not imply that changing the latter hospital's ownership is necessary. Simply changing the hospital's management well might resolve the problem[16]. If the hospital were privatized, both the goals and the management of the organization would change. Which is the active ingredient? Would the organization's performance change primarily because of the change in goals or because of the improvement in management? Certainly bringing in better management should improve the hospital's performance. There is nothing in the available evidence, however, suggesting that also changing goals would yield significantly more improvement.

Introducing investor-ownership would not be a simple matter of finding a buyer, either. The government would have to develop a policy with respect to investor-ownership, and it would have to develop some mechanism to protect patients from "cream-skimming".

One way to deal with hospitals that are currently poorly managed would be to subcontract their management to the management team at another well-run Quebec hospital. Many of the alleged advantages of investor-owned hospitals really are advantages related to membership in a chain of hospitals, as indicated at the beginning of this chapter. If there are gains to be made from multi-hospital systems, investor ownership is not necessary to reap them. Indeed, in the U.S. a growing number of nonprofit hospitals are forming chains of their own. In 1983 there were more hospitals and hospital beds in nonprofit hospital systems than in investor-owned systems[17]. The desirability of forming multi-hospital systems in Quebec should be examined very closely. The utility of doing this is not limited just to poorly run hospitals, either. The possible fusion of the Montreal General Hospital and the Royal Victoria Hospital is a very interesting development.

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[16] This could involve a change in the hospital's key administrators or board of directors.

Given the uncertainty surrounding the effects of a change in a hospital's profit orientation, it may seem tempting to make a test. Sell several hospitals to some private investors, and see what happens. Of course, if such an experiment were to be made, it should only be done in the context of a rigorous, scientifically valid evaluation by a third party. The impact of privatization on access to patient services and quality of care as well as on costs would have to be evaluated. The evaluation would also have to be properly structured so that the effect of the change in the profit orientation could be separated from the effect of the change in management.

But it may be far wiser to observe the U.S. experience with investor-owned hospitals for the next several years. If the investor-owned hospitals there do not prove substantially more efficient--given the DRG-based reimbursement scheme now being used for Medicare patients and the other economic pressures on the hospitals--then there is no reason to think that such hospitals would benefit Quebec[18]. At the same time some effort could be made to study the source of the inefficiencies currently existing in Quebec's hospitals.

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[17] Institute of Medicine( 1986), pp 28-30.

[18] This approach would have several technical advantages, too. Quebec would avoid the considerable expense associated with conducting its own evaluation. The US would also provide us with a much larger sample on which to base our judgments. The one or two hospitals in the Quebec experiment could easily be "special cases". But the US experiment involves hundreds of private hospitals, so this problem would be avoided.

## Consequences for Industrial Relations

A shift in profit orientation could have important implications for industrial relations in the hospital sector. For example, would unions loose their accreditation at hospitals which were privatized? This happened at the Manior Richleau after the resort was privatized in early 1986.

Would investor-owned hospitals abide by the prevailing agreements in the public hospital sector? If workers at investor-owned hospitals were not included in the public sector, they would be placed in a very unreasonable position. On the one hand, they presumably would not be able to use the strike to pressure the hospitals owners, because the right to strike has been effectively eliminated in the hospital sector. On the other hand, they would be under considerable pressure from the owners to accept poorer wages and working conditions. The owners of investor-owned hospitals would find it financially very attractive if they could pay lower wages, have more flexible staffing patterns, and avoid providing job security such as currently exists.

These are not necessarily arguments against privatizing hospitals. Rather, the point is that if some Quebec hospitals were going to be privatized, mechanisms would also have to be introduced to protect the interests of the hospital employees and their unions.

## Appendix:
## Ownership and Performance of American Nursing Homes

American nursing homes are predominately investor-owned; in 1980 81 percent of the homes and 69 percent of the beds were investor owned[19]. There is evidence that their performance is related to their profit orientation. Researchers report that the investor-owned nursing homes have average costs between 5 and 15 percent lower than the nonprofit nursing homes (Hawes and Phillips, 1986; Schlesinger et.al., 1986). The lower costs result, at least in part, from lower patient care expenses. The cost of administration and general services also tend to be lower.

There has long been much concern about the quality of care in nursing homes, particularly investor-owned homes. The available evidence suggests that the nonprofit nursing homes provide better quality of care. After surveying the literature, Hawes and Phillips (1986) concluded, "...the preponderance of evidence suggests the superiority of not-for-profits--particularly of the church related not-for-profits."

### Reasons for Cost and Quality Differences

But these differences in performance may stem from more than just the profit orientation of the nursing homes. Medicaid patients comprise a somewhat larger fraction of the patients in investor-owned nursing homes than in the nonprofit homes[20]. The latter tend to specialize in the treatment of more affluent, non-Medicaid patients. Medicaid rates are typically much lower than the rates paid by the other patients. The low rates plus the need to make a profit result in the investor-owned homes providing lower quality care. If the Medicaid rates were higher, the quality of care would probably be higher and the costs would be higher, too. Thus, it would be wrong to use the cost difference between the investor-owned and nonprofit nursing homes as evidence that investor-owned homes are inherently more efficient.

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[19] Institute of Medicine( 1986), pp. 32.

[20] In 1977 50 percent of the investor-owned homes patients were Medicaid or Medicare patients, while 40 percent of the nonprofit homes' patients were. ( ibid, pp. 111)

The nature of the nursing home sector also makes it easier for the investor-owned nursing homes to provide lower quality of care[21]. First, physicians play a much less important role in nursing homes than they do in hospitals. Physicians are not around the nursing homes very much; they play only a minor role in the day-to-day treatment and care of patients. The non-present physician is not much of a countervailing force against managers who want to reduce the quality in order to save money.

Second, while many American acute care hospitals have had excess capacity, there has been excess demand for nursing home services. This has also made it easier for management to cut quality in order to save money. Third, hospital patients as a group are better able to look after their own interests than are the nursing home patients. The latter are typically much more dependent because of their social isolation and the nature of their physical and mental disabilities. Finally, government regulation of nursing homes has been quite superficial.

Thus, it is not at all surprising that the quality of care is lower in the investor-owned nursing homes. The combination of the lower fees, the nature of the nursing home the sector, and the financial incentives results in lower quality. Consequently, the costs are lower, too. Note that just raising fees would not necessarily resolve the problem, either. If a investor-owned and a nonprofit nursing home each received the same fee, the former would have a greater incentive to compromise on quality, and the nature of the nursing home sector would give the managers considerable room to do so. Ownership is of some consequence.

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[21] Institute of Medicine (1986), pp. 134-137.

Note that the fact that investor-owned homes have lower average costs does not imply that investor ownership means inherently lower costs. These nursing home results should not be used as evidence that investor-owned hospitals would be more efficient than nonprofit hospitals. The lower costs can just as easily be explained by the homes having a captive clientele and low fees.

## Chapter VII
## SUBCONTRACTING MANAGEMENT FUNCTIONS

At least some of a hospital's management functions could be subcontracted to outside organizations. This type of privatization could take a variety of forms. The outside organization might manage a particular service (e.g. housecleaning or computer services) or it might manage the entire hospital. It might only provide key managers, while the actual services would continue to be produced using the hospital's staff and facilities. Alternatively, the subcontractor might manage and produce the services, using its own employees and facilities. Finally, the outside organization might be investor-owned (e.g. an investor-own hospital chain or management consulting firm) or a non-profit organization (e.g. another hospital, for which subcontracting would provide it some supplementary revenue). The type of organization, however, is probably not a very important issue because in either case the subcontractor is trying to make money.

Some Quebec hospitals currently subcontract the management of some services. But none subcontract the management of the entire hospital to a private firm. The question increasingly being asked, however, is whether hospital boards should be encouraged to make greater use of outside management services.

Of particular interest is the potential for outside management of the entire hospital. As in the U.S., outside management might be used to deal with hospitals in trouble because of poor in-house management. Alternatively, it might be used to develop a new mode of hospital administration, whereby a nonprofit organization, whose operation was the responsibility of a community based board, was managed by some sort of profit-oriented team. Would this blending of concerns about "community service" and "profits" improve hospital performance? What does happen when a hospital is managed by an outside organization?

## CONSEQUENCES OF OUTSIDE MANAGEMENT

Outside management, its proponents argue, is a way to reduce hospital costs. They give at least three reasons why outside managers might improve efficiency. First, the outside organization, it is claimed, could provide the hospital with better quality managers because it is able to attract better quality personnel, offering them better pay scales and incentive systems[1]. Second, the outside managers could provide greater expertise. They themselves may have worked in a greater variety of situations. They could also draw on the organization's staff of experts to deal with special problems. The outside managers could be more familiar with up-to-date management techniques. For example, they may have developed better management information systems. Finally, the subcontracting organization might be able to purchase goods and services at lower prices. If it is managing several hospitals, it may obtain lower prices through bulk buying.

But the quest for lower costs may also have some adverse effects on the hospital's performance. First, the quality of particular patient services may be adversely effected by outside management, which is typically rewarded for finding ways to reduce hospital costs, not for improving quality of care. This argument, of course, does not presume anything about the quality of care now provided in Quebec hospitals. In addition, the outside managers might reduce costs by altering the mix of services provided by the hospital, so as to reduce the number of high-cost cases. This is a form of "cream-skimming". As a result, people would have to go elsewhere for services. Of course outside managers are concerned about quality of patient care services. But they have a financial incentive to sacrifice quality that would not exist if they were not being rewarded for reducing costs.

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[1] This is a tricky argument. Given that there is some variation in the quality of managerial talent, there could be some truth in this argument. If an outside firm recruited some of the most talented managers, it would be able to provide a better quality of management to a hospital stuck with on of the least talented managers. But this does not prove the general proposition that outside management firms inherently have better managers than hospitals' in-house managers.

Several important qualifications are necessary. Outside managers often do not unilaterally make reductions in quality and changes in service mix. There are limits on what they themselves can do. Such reductions and changes generally also require approval by the hospital's board and in some cases the government. Moreover, it is also possible that outside mangement could improve quality in some cases. At a poorly managed hospital, patient care may be disorganized and staff morale low.

Second, outside management can also effect hospital performance through its effects on the hospital's staff. Outside management can have a variety of effects on in-house managers, for example. On the positive side, the outside managers may teach current managers some new tricks and motivate them to perform better. On the negative side, some current managers could be demoralized if hospital boards turn to outsiders to solve all their problems, and some talented, experienced managers may be lured away by outside management firms. In most discussions of the impact of outside management on hospital staff, attention is focused on the situation at a particular hospital. Some thought, however, should also be given to the system-wide effects. Such effects, which may be very important, are discussed at the end of this chapter.

## EMPIRICAL EVIDENCE

Although subcontracting is not a new idea and its use is growing, few serious attempts have been made by researchers to evaluate the consequences of outside management for hospitals' performance. And what evidence is available involves analyses of only the cost consequences for a limited number of American hospitals whose entire management has been subcontracted.

There has apparently not been any systematic research on the consequences of subcontracting particular services, though at least there is some positive Canadian anecdotal evidence. According to l'Association des hôpitaux du Canada(1985)

> "...quoique la pauvreté de l'information sur la gestion rende difficile d'identifier avec précision des coûts particuliers, il semble bien que les avantages des connaissances spécialisées de service particuliers et les économies d'échelle aient rendu attrayante l'option de la gestion par contrat de services de soutien pour de nombreux petits hôpitaux du Canada. Dans certains cas, les témoignages font penser que les coûts globaux ont vraiment diminué ou que la qualité des services s'est améliorée sans frais supplémentaires grâce aux services contractuels."

Unfortunately, there is little evidence concerning the impact of outside management on patient services. What evidence is available presents a conflicting picture. Using U.S. data, Rundall and Lambert(1984) present some evidence that subcontracting often results in a curtailment of the services, while Biggs et.al.(1980) present some evidence that subcontracting results in some expansion of services.

Moreover, it is certainly plausible that patient services may be improved in some situations. This is underscored by the experiences at the Hawkesbury General Hospital, the much discussed sole Canadian case of outside management of the entire hospital (see below). After the switch in management in 1983, staff education expenditures increased substantially, a plan was adopted to update the hospital library, a full-time physiotherapist was added, and dietary counselling and ultrasound services were introduced (Lacroix, 1984). But this is a single case, and most observers agree that the hospital was badly managed before the outside management was introduced. Thus it is difficult to generalize from this experience. It does indicate, however, that the quality issue is complicated.

## Effects on Hospital Costs

The available literature is small, all the evidence coming from American case studies. The research methods are not very polished, either; the samples used have been small and the controls for other cost determinants poor, making it difficult to isolate the outside management effects. Stoddart and Labelle (1985) provide a good summary of this literature:

> "The evidence from the U.S. suggests that few differences exist in the costs of production between contract managed and in-house managed hospitals, and when cost differences do emerge either they tend not be significant or methodologic problems render the results inconclusive."

By way of illustration, consider the results of the most recent evaluation of outside management (Kralewski et.al.,1984). These researchers collected data for 20 matched pairs of non-profit community hospitals scattered across the U.S., one hospital of each pair having outside management. They then compared the performance of each pair during the three year period preceeding the introduction of outside management and the three year period following it. They found no evidence that the outside management had any effect on hospital costs. The performance of the outside-managed hospitals did not differ significantly from that of the conventionally managed hospitals with respect to the number of employees per bed (or per patient), payroll expenses as a fraction of total expenses, length of stay, or beds.

But the researchers did find that the outside managers improved the hospitals' financial performance by increasing their patient charges. The hospitals' average mark-up rose after outside management was introduced relative to what it had been in the preceding three years, and relative the mark-ups of the inside-managed hospitals.

These results are not surprising. Outside management appears to have the same financial effects as investor-ownership of hospitals. As explained in the preceding chapter, during the 1970s and the early 1980s, U.S. hospitals had little incentive to reduce costs. Additional "profits" could be generated relatively easily by raising the rates charged the various insurance companies. Thus, when either an investor owned hospital or outside-managed hospital sought to improve its financial situation, it concentrated on raising rates rather than reducing costs.

Since outside management was used to improve the performance of the Hawkesbury General Hospital, interest in outside-management has increased in Canada (Deshaies, 1984; Lacroix, 1984; LeTouzé, 1986). In 1983

American Medical International (AMI) took over management responsibilities. But it is unreasonable to assume that introducing outside management at other hosptials would yield similar results. Hawkesbury is a special case. That hospital was badly managed before the outside manager arrived, so it is not surprising that a new manager has improved the hospital's financial performance. But bringing in outside management probably was not necessary to improve the situation. The hospital's performance could have been greatly improved if the hospital had simply hired a competent new director general[2]. The steps the new manager took to reduce costs were quite straight forward. He made some staff reductions via attrition, improved cash flow thereby reducing borrowing costs, provided department heads with better financial information, and eliminated unauthorized long-distance telephone calls (Deshaies, 1984). There is no reason that the hospital could not have hired a competent manager who would have done the same things[3].

## OUTSIDE MANAGEMENT FOR QUEBEC HOSPITALS

The idea that outside management is needed in Quebec hospitals presumes that there is a "management" problem. If there is one, it is not documented in the research literature. Before deciding to make greater use of outside management, more information is needed about the state of management in Quebec hospitals today. Is subcontracting a prescription in search of a problem? Are we reacting to stereotypes about public-sector management, perhaps based on a combination of ideology and management problems south of the border, or is there a significant management problem? Is there a problem at 5 hospitals? 25 hospitals? 125 hospitals? If we are only looking for a way to save $2.34 at two small hospitals, it may be a waste of time to have a long debate over the methods of doing it.

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[2] Indeed, the reason the hospital opted for outside management had little to do with the quality of the managerial skills per se. Rather the deciding factor was apparently the willingness of American Medical International to help the hospital obtain a bank loan to finance the construction of a new wing.

[3] There is one source of savings available to the AMI manager that would not have been available to a newly hired manager: the AMI was able to buy goods at lower price because AMI is a large chain, whcih can buy things in bulk and save money. However, this was not the major source of the savings at Hawkesbury.

If there is a significant problem, however, what is its cause? A diagnosis is needed in order to judge whether the prescription is appropriate. Are the public managers incompetent? Have they unfortunately been unable to get the management tools they need because of budgetary stringencies? Or have they been paralyzed by excessive provincial regulations? New managers might be necessary for the first diagnosis, but not for the last two. More is said below and in Chapter X about ways to strengthen existing management.

Not only is the problem itself ill-defined, but the effectiveness of the proposed remedy is not apparent. There is currently little evidence available indicating that outside management--at least outside management of the entire hospital--would in fact significantly improve hospital efficiency. The available evidence, as summarized above, suggests that outside management of an entire hospital has no systematic effects on hospital costs. It certainly does not indicate that there would be savings great enough to warrant the government spending a lot of time and effort developing programs to facilitate outside management services. This should make one wary of widespread use of outsiders until such evidence is available.

Finally, it is important to realize that little is known about the impact of outside management on the quality of patient care services. The fragmentary evidence is inconclusive, though it does indicate that the issue is complex because outside management in some cases may improve patient care. The seriousness of this issue, however, depends on several things. One is the role of outside management; outsiders could have a greater impact on quality if they were looking after the entire hospital than if they were only managing computer services. The potential for problems also depends on the constraints under which the outside managers operate. This would depend, as already noted, on the behavior of the hospital's board and the government.

For example, it has been suggested that some government monitoring of hospital behavior might help avoid problems (Evans, 1984). Although feasible in principle, in practice would monitoring work? Certainly provincial monitoring in other areas of other social concerns (e.g. human rights and compliance with minimum wage laws) leaves much to be desired.

## The Management Contract

The nature of the management contract itself would be important in shaping the performance of the hospital with outside managers. Typically, such contracts provide the managers with a financial incentive to improve the hospital's performance. For example, the outside management organization might receive a percentage of any cost savings. In the case of the Hawkesbury General Hospital, AMI received a $300,000 annual management fee plus 50 percent of any budget surplus exceeding $750,000. Thus, there is certainly an incentive for AMI to improve costs.

Whether it would also be possible to give the outside managers a financial incentive to maintain or even enhance the quality of patient care services is more problematical. Evans(1984) has observed that it might be. Although he was not on a soapbox advocating outside management, Evans suggested an arrangement whereby the hospital would receive from the government a capitation payment for a prescribed group of people, and then it would be required to finance all hospital services these people received, whether provided by itself or other hospitals. This would certainly reduce the incentive for "cream skimming" because the hospital would pay for the services wherever they were provided[4]. But such a scheme would convert the hospital into a one-legged HMO -- one-legged because it would be responsible for hospital services, but not for physician services. Two-legged HMOs are much more attractive (Chapter IX). It would be preferable to stimulate their development, rather than mess with their handicapped cousin.

## Impact on Public Management

Underlying the interest in outside management, as noted above, is the belief that there are currently problems with the management of Quebec hospitals. This is possible. Suppose it is true. Turning to outside management, however, would be an unnecessarily circuitous solution. A much more direct solution would be to improve the performance of the current in-house management. As in the private sector, there are some very talented people now managing some Quebec hospitals, and some who are less talented. But there is certainly no convincing reason to believe that the basic talent of current in-house managers is inferior to that of their private sector counterparts. Current management problems are much more likely to be related to the managerial practices now being used--practices which can be changed.

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[4] The problem would not be fully resolved, however, because the hospital would certainly have a incentive to avoid enrolling people who would likely become "expensive" patients. This type of problem is discussed further in Chapter IX.

There are a variety of possible ways to improve managerial practices. For example, if Quebec hospital managers are not using up-to-date management techniques, that should be changed. There is no obvious, inherent reason why this could not be done. If savings are possible from even more bulk buying, that too is feasible. If current managers are not well motivated because they have poor pay scales and incentive systems, then why not improve their pay scales and incentive systems[5]. If current managers are unduely constrained by provincial regulations, deregulation could solve that.

The Quebec hospital system includes more than 200 hospitals; even by American standards, this is a large chain. Some outside management firms may be large relative to a single 123 bed hospital, but few--if any--are as large as Quebec's system. This size should certainly facilitate the development of multi-institutional management structures, allowing Quebec to exploit any possible economies of scale in management. It is also certainly big enough to provide managers with a wide variety of experiences. Encouraging some managers to do some consulting with other hospitals would expose them to new problems, and it would bring their experiences to bear on new problems.

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[5] If the public hospitals do have problems attracting and retaining good managers, some of these changes should make Quebec hospitals a more interesting and rewarding place to work.

If there are currently management problems, strengthening the practices of current in-house managers is not only a more direct solution for them, but also it is something that must be done[6]. The system is going to continue to be managed largely by in-house personnel. Thus, if there are problems with current management practices, these practices must be improved in order to improve the performance of Quebec's health system. Improving them should be a very high priority for the government.

But there is a substantial danger that it will not be done if the government devotes time and energy encouraging the development of outside management, as le Groupe de travail has suggested. If Quebec were to adopt a policy of encouraging outside management, the government's limited resources would be focused on the implementation of that policy, and there could be little time or talent left to improve the performance of current managers. Moreover, it is quite possible that the need to improve it would not be recognized; the sign over the Minister's desk would read "management improvement by outside managers".

## Final Observations

If there are significant, widespread management problems in Quebec hospitals, a very high priority for the government should be the introduction of improved management practices. The development of HMOs may also be a desirable way to deal with such problems. More is said about these two themes in Chapter X. The use of outside management should be limited to special situations. The outsiders may provide useful consulting services, the health and cost effects vary among the studies, at least in part because of variation the the quality of the methods used. Thus, it is possible to find a particular study which provides at least some support of most any point of view.

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[6] Certainly outside management could not replace the bulk of the current management of Quebec hospitals, at least not in the foreseeable future. Even if it were desirable, it would not be feasible because there would not be sufficient outside managers.

Nevertheless, there is a pattern in the findings, so the assessments of home care by the reviewers of the literature are quite similar. A report for the U.S. General Accounting Office (United States, 1983) concluded:

> "Expanded home health (care) can reduce nursing home use only for some of the subpopulations; the effect of expanded home health (care) on hospital use is still unclear; some client outcome measures have shown improvements; while individual nursing home or hospital costs may have been reduced, total healthcare costs increased."

Weissert(1985) concluded:

> "Few public policy proposals are more appealing than the notion that sick old people can be cared for better and more cheaply in their homes than in nursing homes. Indeed, the very idea that home- and community-based long-term care will not save money seems counter-intuitive. Yet, after a decade of research, the facts as we now understand them make that conclusion unavoidable. Community care rarely reduces nursing home or hospital use; it provides only limited outcome benefits; and, to this point, it has usually raised overall use of health services as well as total expenditures."

Hedrick and Inui(1986), after the most thorough review, concluded:

> "...home care programs do not appear to affect mortality rates for individuals to whom these services are rendered. ... The majority of studies reviewed support the contention that home care has no impact on physical function, although the experimental study with the highest methodologic rating showed a positive impact. ... Our analysis would suggest that home programs either have no effect on inpatient hospitalization (seven of ten studies), or actually tend to

## Chapter VIII
# FAMILY CARE

Family care refers to arrangements whereby family members or close friends have considerable responsibility for caring for a patient. They may provide some needed services themselves, and they may arrange for others to provide some services, too. As indicated in Chapter II, family care can be a substitute for some hospital services. For example, parent care for hospitalized children is a substitute for nursing services, day surgery can replace inpatient surgery, and home care programs are a substitute for some institutionalization. There is certainly interest in making more use of such arrangements. Although there are a variety of forms of family care, only three are reviewed here. But these three are important forms, and they provide illustrations of the basic issues involved in family care.

Increased use of family care would be one way to privatize the provision of services. Some patient care responsibilities would be shifted from public institutions to private individuals--generally mothers and daughters! Moreover, some treatment costs would be shifted to private individuals, as well. The costs would include out-of-pocket expenditures for services, drugs, professional services and appliances that would have been publicly financed if the patient had remained in the hospital. The cost would also include the value of the time required of family and friends to provide the necessary services; these costs would be explicit when earnings are foregone or implicit when non-remunerated time was involved.

## EVALUATION CRITERIA

There are three relevant outcome measures. First, the impact of family care on the health of the patients. It is important to determine whether it has systematic, negative effects on their health. Some proponents even argue that it should improve patients' health. A broad range of health measures would seem relevant: for example, the probability of death, physical and emotional health, social functioning, and satisfaction with the care received.

The second outcome measure relates to treatment costs. A primary reason for the interest in family care is the belief that it would reduce health costs because "cheap" family care would replace "expensive" hospital care. Both modes of care, of course, would involve various publicly financed services. Day surgery does not eliminate the need for all hospital services, for example. Such costs would include those for hospital, home care, and physicians' and other health professionals' services; the the cost of each service need not be the same for each mode. Both modes would also involve some out-of-pocket costs for the patient and his family. Allowance would also have to be made for the value of the family's time.

The final outcome measure relates to the impact of family care on the well-being of family and other primary care givers. Caring for sick family members can be a positive experience, giving great satisfaction. It can also be an emotional and physical burden. Of course, different families may react differently to the added caring responsibilities.

Given that the primary focus of health policy in Quebec the past 25 years has been on improving the welfare of the sick, the impact of family care on the patients and their families should be of great concern. These are people for whom privatization could certainly have negative effects. Thus, information about the "private consequences" of family care is of central importance for any evaluation of this form of privatization. The "private consequences" include the impact of family care on patients' health, on the costs borne by the family, and on the family's well-being, .

As all researchers do, the researchers trying to evaluate family care have encountered a variety of serious methodological problems. For example, measuring "well-being" is difficult. Researchers continue to have trouble measuring costs. All too often, for example, they calculate the effects of family care on spending by government or insurance companies, but not the effect on social costs. Little will be said about these problems in what follows, however. Although discussing them would make this evaluation more complete, it would not change the basic conclusions that eventually emerge.

## PARENT CARE

With this form of family care, parents' time--most probably mothers' time--substitutes for skilled nursing time. A parent remains with her hospitalized child, providing it many services under the supervision of a nurse co-ordinator. To facilitate this type of care, the parent and the child are kept together in a special room with beds for both child and parent.

The cost consequences of parent care have been evaluated by Evans and Robinson (1983). This is apparently the only detailed economic analysis of parent care. They have compared the hospital costs of having the children in a parent care unit as opposed to their being in a conventional nursing unit, using data from the Children's Hospital in Vancouver, British Columbia.

There were both medical and surgical cases. These researchers do not investigate the health consequences of parent care; they indicate, however, that there is already substantial evidence that parent care yields better health outcomes.

## Reduced Treatment Costs

They estimate that hospital costs were reduced by $46,102 (in 1975 dollars) for the 288 children who were subjected to parent care. This is equivalent to a savings of $160 per case. Note that when Evans and Robinson made their calculations, they assumed that the nursing unit beds that the 288 would have needed were closed and that the appropriate staff reductions were made; the cost savings would have been much less if there were no offsetting reduction in resources in the nursing unit--if the parent care unit were only an additional service[1].

A most striking feature of their calculations is that they make no allowance for the private costs of either mode of treatment. The authors argue that this is reasonable, given the nature of their study. Because the private consequences of family care are such an important issue, it is worth examining their argument briefly. Theirs is a retrospective study of a situation in which parents ostensibly had free choice between parent care and conventional nursing care. The people who elected parent care were people who--at least beforehand--expected that their increased well-being from being with their child would out-weigh any financial or other burdens they would have to bear. In short, these people thought they would benefit from being with their sick child.

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[1] They make no allowance for the impact of parent care on the cost of physician services. It is tempting to think, however, that if they had, the savings would have been even larger. Their data suggest the parent care may reduce the children's length of stay and the number of tests done, which would translate into lower physician costs. However, there is a complication, which would not appear in their results: if parent care were widely used and it did initially cause some reduction in pediatric services, physicians might well adjust their practice patterms in order to avoid substantial declines in the incomes in the long run. The result could be no significant savings in the cost of physician services.

If Evans and Robinson had made allowance for the private costs, they would also have had to make allowance for the benefits. But this would only have strengthened their conclusion. Not only did parent care reduce institutional cost, but also it made the families involved better-off.

Note that this approach does not imply that the private consequences are unimportant and can always be ignored. This approach is only applicable in situations were net benefits have actually been "revealed" by people's actions[2]. In the situation analyzed by Evans and Robinson, some people had revealed by their actions in a non-experimental environment that they preferred to remain with their children, all things considered[3].

One consequence of their approach, of course, is that their results are only applicable to families who elect parent care such as the Vancouver families did. The results do not imply that parent care is applicable to all hospitalized children. It is not suitable for some health problems. Moreover, some people may have prefer not to use it. In the Vancouver research 288 children received parent care, but another1501 who were judged eligible for it actually received conventional nursing care. Why? Evans and Robinson do not indicate whether the parents of these 1501 children were given a choice and elected nursing care; or whether some parents preferred parent care, but could not use that mode because the parent care unit was full.

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[2] A word of caution: it is important for evaluators to determine whether people who initially opted for a service changed their mind about it after experiencing the service. People might opt for a program because it sounded good. But if it proved to be a bad arrangement, there would be few return customers. (This point is well-illustrated in the discussion of day surgery later.) Moreover, word might spread that the service was undesirable. The expected positive net private benefits would turn-out to be negative, and the calculations of the sort made by Evans and Robinson would at minimum overstate the social benefit of the program; they could also erroneously indicate that programs were social beneficial.

[3] Their approach is attractive because it eliminates the need to evaluate the private consequences, the measurement of which is messy to say the least. But if a researcher does a random controlled trial for everyone in a group of people at risk, the "private consequences" cannot be ignored because people have no way to "reveal" by their actions their preferences. Alternatively, the RCT could be limited to people who indicated a willingness to participate in the program to be evaluated. But this raises two problems. One is that the results could not be generalized to everyone; this is the Evans and Robinson problem. Second, it implicitly assumes that private consequences alone should determine the fate of programs. But, that some people prefer not to use a program does not necessarily mean that the program is socially undesirable. If a program would save 10 million dollars and enable surgeons to use their time more productively, should it necessarily be rejected because the well-being of 8.5 patients and their families would be reduced?

## Comments

The results of this single study certainly suggest that parent care would reduce health costs. Evans and Robinson suggest that wide spread use of parent care could yield substantial savings. They estimate that it reduced hospital costs by $160 per case on average. Moreover, they suggest that as much as 30 percent of the pediatric workload in British Columbia could be treated using parent care.

The introduction of parent care would require some initial investment spending in order to make the necessary conversions to existing pediatric hosptial facilities. But, it would appear that the additional government spending would be warranted; in the long term hospital costs would be reduced and health improved. Parent care for at least some families would enhance social welfare by reducing institutional costs, by improving the children's health, and by improving the well-being of the families. This is an attractive package!

## DAY SURGERY

This form of family care involves people going to the hospital in the morning for surgery and then after a period of observation returning home before nightfall. Depending on the type of surgery, the patient could return to the hospital later for follow-up treatment, or the hospital could provide some follow-up services in the patient's home. A variety of child and adult surgical cases are now being managed this way, including cases involving reductions of fractures, plastic surgery, varicose veins, tubal ligation, hernia repair, circumcision and cystoscopy[4]. Day surgery need not even be done at hospitals; in the United States day surgery is being performed at a rapidly growing number of free-standing "Surgi-Centers".

The most comprehensive evaluation of day surgery for adults has been done here by Pineault et.al. (1985b). They conducted a random controlled trail involving 182 patients at a single Montreal hospital to analyze the consequences of day surgery for three surgical procedures: tubal legation, hernia repair and meniscectomy. There was some preliminary screening of the patients, however. All 182 were people whom the surgeons thought were eligible for day surgery and who were indifferent between the two surgical modes, day surgery and conventional in-patient surgery.

There have been other evaluations of aspects of day surgery. For example, Robinson and a number of collaboraters have evaluated day surgery for children based on experiences at the Children's Hospital in Vancouver, British Columbia (Shaw, Robinson et.al.,1972; Evans and Robinson,1980).

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[4] Evans and Robinson (1980) list more than 26 different surgical procedures performed on children in the surgical day care unit at the Children's Hospital, Vancouver, British Columbia.

Health Outcomes

The results suggest that day surgery had no significant effects on the health of the patients. A variety of health outcome measures were used, including the incidence of post-operative complications, physical functioning and a self-appraisal of general health status. When the values of each measure for the people in each of the two surgical groups where compared, there were no statistically significant differences. This result is consistent with the findings of other researchers, too (Kornhall and Olsson, 1976; Ruckley et.al.,1973; Shaw et.al.,1972).

However, there does seem to be a problem of patient acceptance. The day surgery patients were much less satisfied with their treatment than were the conventional surgery patients. Fewer thought their length of stay was "appropriate" and a substantially smaller proportion would use the same mode of treatment (i.e. day surgery) again. Although all patients were indifferent at the outset between mode of treatment, barely a majority of the Day surgery patients (i.e. 51 percent) would use the "same mode" again. In comparison, 87 percent of convention surgery patients would use the "same mode" again. Kornhill and Olsson (1976) also report much less satisfaction among the day surgery patients[5]. Unfortunately, no attempt was made to determine the reasons for the dissatisfaction, or to identify the characteristics of the patients who were satisfied and who were dissatisfied. Such information would be useful when developing day surgery programs.

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[5] This result re-enforces the point made earlier when discussing the parent care results that it is important to evaluate people's perceptions of a program after they have used it.

## Reduced Treatment Costs

Treatment costs in the Pineault study include not only the cost of in-patient and out-patient hospital services and physician services, but also private costs (i.e. out-of-pocket spending plus some allowance of the value of unpaid time[6]). The impact of day surgery on treatment costs was not the same for all three types of surgery. It reduced treatment costs by 19 percent for tubal ligations and by 26 percent for hernia repairs, but it increased treatment costs by 3 percent for meniscectomies.

Other researchers have also reported that day surgery can reduce costs (Evans and Robinson, 1980; Saltzstein, 1974), though their cost measures are not as comprehensive as that of Pineault. Evans and Robinson, for example, estimate the effect of day surgery for children on just hospital costs. The savings seem impressive; they estimate that day surgery saved at least 57 percent of the cost of in-patient care!

One of Pineault's striking results is that the private costs were lower for the day surgery mode, though the differences are not statistically significant. This is surprising because it is frequently thought that family care is more costly for the patients and their families[7]. With available information it is not possible to determine whether this conventional wisdom is wrong, at least for this form of family care, or whether this result stems from the peculiarities of the particular cases included in the Pineault study.

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[6] Valuing upaid time is difficult; Pineault used the minimum wage, which is surely a lower bound on the value of people's time.

[7] The source is not the same for each of the three types of surgery. For tubal ligation, the cost of unpaid help is higher for the conventional surgery patients. For hernia repair and menniscectomy, salary losses are greater.

Comments

Subject to one signficant qualification, day surgery seems to be a reasonable way to provide some surgical services. The qualification stems from the fact that little is known about the effect of day surgery on the well-being of the patients' families. Unfortunately, Pineault et.al. did not assess this effect. The literature on this important aspect of day surgery is very sparse. Apparently, the only evidence comes from one study (Shaw,1972), in which it was reported that the parents of children who underwent day surgery were as satisfied as parents of the children who had conventional surgery.

Although day surgery may be desirable, it is not for everyone. The best evidence is only related to three surgical procedures, and there is certainly no reason to think that these results can be generalized to all procedures. No one, however, has proposed that Day surgery should include open heart surgery. Moreover, many patients may not be eligible for day surgery. Pineault et.al. report that while their study was in progress the three surgical procedures were performed on 672 patients at the hospital where the research was done. But the surgeons thought that only 44 percent of these patients were eligible for day surgery.

People's attitudes toward day surgery may also be a significant constraint on the use of this procedure. Pineault et.al. report that when potential patients were asked about their preferences before being included in the study, only 8 percent of those eligible for day surgery had a strong preference for conventional surgery[8]. But the apparent high level of dissatisfaction among people who used day surgery is troubling. Unless this high rate of dissatisfaction is reduced, this mode could get a bad reputation, limiting the number of people in the future willing to use it. This widespread dis-satisfaction also means that it is possible for the evaluator to be reasonably confident that day surgery was socially desirable in only about half the cases studied by Pineault et.al.

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[8] These patients were assigned to the conventional surgery mode, and dropped from the study group.

It would certainly seem desirable that the reasons for the dissatisfaction be studied. One possibility is that the private costs of day surgery are higher than Pineault et.al. suggest. Another is that many families' well-being was adversely affected. Still another is that the result is spurious; some people may have blamed their discomfort on the "experimental" procedure, rather than on the real cause, the surgery itself.

Day surgery also requires some infra-structure, for which some organization must be responsible. Some patients may require medication and assorted out-patient services. In the case of meniscectomy, for example, home nursing services and physiotherapy are necessary. For day surgery to prove socially acceptable, these services must be available and accessible. If people have trouble getting appointments for out-patient treatments or experience long waits for scheduled appointments, for example, they may become disenchanted with day surgery.

## HOME CARE

With this form of family care, a variety of services are made available to people in their own homes. According to the proponents of home care, this should allow people to leave hospitals, chronic care institutions and nursing homes earlier, and in some cases to avoid having to go to them in the first place. Several advantages are suggested. One is that patients and their families are happier when they can be outside of institutions. But the main attraction for most health planners seems to be the claim that such programs can reduce health care costs by substituting "cheap" home care for "expensive" institutional care.

Home care, as practiced throughout North America, refers to a very heterogeneous collection of programs. This is an important fact to bear in mind when reflecting upon the evaluations of home care found in the literature. The programs vary in terms of the health problems with which they deal (e.g. stroke patients, patients with arthritis, general health problems). Most, however, focus on people with chronic health problems, and the majority are people 65 and over. In addition, the types of services provided vary, too. The services include skilled nursing care, physical and occupational therapy, homemaker services (including "meals on wheels" type services), social services, transportation, medical and surgical supplies, home visits by physicians, and home health aids. Finally, the programs are structured in a variety of ways. Some are hospital-based, others are community based. Most are operated by non-profit organizations or by government agencies.

## Consequences of Home Care

Given all the interest in home care programs during the past 15 years, it is surprising that the existing evaluations of them are not very supportive. A large number of evaluations of home care programs of one sort or another have been made during the past 20 years. These studies have been reviewed in a series of articles that have appeared in recent years (Hammond, 1979; United States, 1983; Lave, 1985; Hughes, 1985; Weissert, 1985; and Hedrick and Inui, 1986). As is normal, the results with respect to the health and cost effects vary among the studies, at least in part because of variation the the quality of the methods used. Thus, it is possible to find a particular study which provides at least some support of most any point of view.

Nevertheless, there is a pattern in the findings, so the assessments of home care by the reviewers of the literature are quite similar. A report for the U.S. General Accounting Office (United States, 1983) concluded:

> "Expanded home health (care) can reduce nursing home use only for some of the subpopulations; the effect of expanded home health (care) on hospital use is still unclear; some client outcome measures have shown improvements; while individual nursing home or hospital costs may have been reduced, total healthcare costs increased."

Weissert(1985) concluded:

> "Few public policy proposals are more appealing than the notion that sick old people can be cared for better and more cheaply in their homes than in nursing homes. Indeed, the very idea that home- and community-based long-term care will not save money seems counter-intuitive. Yet, after a decade of research, the facts as we now understand them make that conclusion unavoidable. Community care rarely reduces nursing home or hosptial use; it provides only limited outcome benefits; and, to this point, it has usually raised overall use of health services as well as total expenditures."

Hedrick and Inui(1986), after the most thorough review, concluded:

> "...home care programs do not appear to affect mortality rates for individuals to whom these services are rendered. ... The majority of studies reviewed support the contention that home care has no impact on physical function, although the experimental study with the highest methodologic rating showed a positive impact. ... Our analysis would suggest that home programs either have no effect on inpatient hospitalization (seven of ten studies), or actually tend to

> increase the use of hospital bed-days (two of ten studies, both experiments with the highest possible criteria scores). Similarly, the provision of home care services may actually increase ambulatory care service utilization by approximately 40 percent. ... We are unable to substantiate the contention that home care program services reduce expenditures for medical care."

Moreover, it is not clear from this literature that home care improved patients' satisfaction with the care they received. Zimmer et.al. (1986) found the home care program they studied had no effect on patient statisfaction. Hughes (1985) reports that in only 2 of 13 studies reviewed was patient contentment considered. In both cases, however, home care did improve patient satisfaction.

## Reasons for Negative Evaluations

These results certainly give little support to home care programs, either as a means of reducing costs or as a means of improving people's lives. Of course, it is possible that home care is inherently cost-augmenting and has no significant effect on health. After all, there is no reason to think that ineffective health services are limited just to clinical tests, surgical procedures, and drugs.

But there are other possible reasons for these results, which make it impossible to dismiss home care out-of-hand. Not surprisingly, the methods used by most researchers certainly leave a great deal to be desired[9].

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[9] Three recent studies provide illustrations of some of the methodological problems (Dranove, 1985; Wade, 1985; and Zimmer, 1985): The home care program was not well integrated into the hospital, and it did not differ very much from already existing community-based programs(Wade); poor statistical modeling (Dranove); sensitivity of health status instruments not indicated; patients selected in a way that could bias results (Wade); and faulty cost calculations (Dranove,Zimmer).

In addition, as already noted, home care is a very heterogeneous collection of programs, so some may be socially desirable and others not. Hughes (1985) notes that three quite different types of programs have been evaluated by researchers: skilled nursing and therapy services; "expanded" home care services and "channeling" programs. He then suggests that the results might be quite different for each type. That, of course, is plausible. But the evidence he presents, based on his review of the literature, suggests that the results for each type are in fact similar: no strong case can be made for the social desirability any of the three types of programs.

Another explanation is that the programs have not been well-targeted on the people who would benefit from them. For example, it is frequently argued that in most of the studies the people in both the home care and non-home care groups were unlikely to be institutionalized, so it is not surprising that institutional costs were not significantly different between the two groups (Weissert, 1985). However, though poor targeting has been a frequently mentioned explanation for the negative results, no one seems to have had much success identifying particular groups of people who would benefit from particular types of services (Lave, 1985).

Thus, the existing evidence does not conclusively demonstrate that home care is socially undesirable. However, the burden now is on the proponents of home care to demonstrate that certain types of programs are desirable. It is possible that newly structured programs plus better research methods would yield some favorable results. But it would seem unreasonable to put more resources into this way of privatizing health services until such evidence is forthcoming. Certainly any new programs should be subject to scientifically valid evaluations as a condition for government financial support. Moreover, existing programs should also be carefully reviewed.

## Lack of Evidence on "Private Consequences"

Surprisingly little attention has been paid to the "private consequences" of home care programs by either the researchers or their subsequent reviewers. Yes, researchers have studied the impact of home care on the patients' health. But when the treatment costs have been estimated, the focus is on institutional expenditures--the costs borne by governments, hospitals and insurance companies. The private costs are generally ignored! For example, Hedrick and Inui (1986) indicate that they could find only 11 studies of home care that they thought were reasonable methodologically. In only 7 of these 11 studies were the the cost effects estimated, and in only 2 of them was any allowance made for the private costs. Moreover, the treatment of private costs was not very good in either of them.

Furthermore, almost no attention has been given in these evaluations to the impact of home care on the well-being of other family members. In apparently only one of the 11 studies reviewed by Hedrick and Inui was this considered (Zimmer et.al.,1985). In that study evidence was presented that family members well-being was improved by home care, but this was caused primarily by the fact that they knew that a competent physician was available and they liked him. The program being evaluated, however, used only one physician, so the families' increased satisfaction may be more related to that particular physican than to home care *per se*.

## Financing of Home Care Services

The proponents of home care have frequently claimed that insufficient resources were available. In retrospect, in light of the results of the evaluations of these programs, restricting the flow of dollars into these programs may appear desirable. But the social desirability of doing that depends on the alternatives available to the clients of the programs. The research findings suggest that there is no reason at present to prefer home care over traditional institutional care, and that institutional care may even be preferrable. But the findings do not justify doing nothing for the people involved. Certainly they do not justify limiting home care resources while at the same time encouraging hospitals to discharge patients sooner into non-existent or resource-starved home care programs. Either the people should be served by adequately financed home care or adequately maintained in hospitals and nursing homes.

Note that the home care programs which have been evaluated by the researchers were seemingly amply funded. Such programs apparently at least managed to maintain their clients' health. But what would have happened if the people had been placed in underfunded home care programs?

There are also several significant issues related to the structure of a public financing program for home care. First, should people on home care have to pay for services they would have received free if they had been hospitalized? Drugs are free for people while in the hospital, for example, but not necessarily if they are discharged early into a home care program. This is an undesirable policy. It does not encourage people to use home care services. Moreover, such charges would be a form of user charges, and there is no convincing reason why this particular form of a user charge would be any more socially desirable than the forms evaluated in Chapter IV.

In addition, should there be some sort of financial support provided to the families of people on home care? This would provide some compensation for the incidental out-of-pocket costs as well as for the family bearing an increased share of the burden of caring for the sick. What mechanism should be used? Direct payments? Tax deductions? It would be easier to discuss this issue if more information were available about the private consequences of home care.

## CONCLUDING COMMENTS

Three forms of family care have been reviewed here; other forms are possible, too. All are ways to privatize the provision of health services. There is no reason, of course, to think that all forms of family care would have identical effects. Indeed, they do not. Quebec would benefit from the development of parent care and the expansion of day surgery. The former would probably both improve health and reduce health costs, while the latter reduce health costs. But home care programs are quite a different story. It appears that the very best that can be said for them is that they change nothing. They apparently neither improve health nor reduce costs.

Although the development of parent care and day surgery appears warranted, it should proceed with some caution. Much of the key evidence comes from a single study in each case. Thus, some additional evidence for both would be desirable before they are widely diffused. Additional evidence would be useful not only to confirm that these two forms of family care are socially desirable, but also to help shape the structure of both services. The structures of both are still not well-defined. In the case of day surgery, there was much dis-satisfaction with the service; about half of the people who used it would not be return customers. Is this the result of a faulty methods of measurement? Or does it indicate that the structure of the service needs polishing?

Moreover, the appropriate scope of both day surgery and parent care are uncertain. Certainly, neither is appropriate for all health problems. Obviously caution is warranted in using such services for health problems for which there yet is not yet evidence of the health or cost consequences. Moreover, neither is appropriate for all patients with the health problems for which these services appear in principle to be warranted. The reseachers themselves are quite clear that all children should not be treated using parent care and that all tubal ligations, hernias and meniscectomies should not be treated with day surgery. But even if a parent care program is introduced modelled on Evans and Robinson's research protocols, social welfare will be enhanced. Although the development of day surgery also is warranted, the structure of the program needs some further thought because of the high level of patient dissatisfaction.

## Chapter IX

# HMOs AND PRICE-COMPETITION

Without doubt one of the most widely accepted ideas among health planners is that Health Maintenance Organizations (HMOs) are a desirable way to provide health services. They are viewed as being reasonably efficient and, at least in the American context, as providing reasonable access to health services. For example, Manning et.al (1984) compared the health costs for two well-matched groups of people, one group which belonged to an HMO and the other which used the conventional fee-for-service system. The per capita cost for the HMO group was at least 23 percent lower. Indeed, if there is a desirable feature of a health system, one can probably find some researcher claiming that HMOs would facilitate its attainment[1].

Not surprisingly, there has long been much interest in them in Quebec. More than15 years ago the Castonguay Commission admired the performance of the HMOs in the United States, and subsequent commissions in the early 1970s elsewhere in Canada did, too (e.g. Canada, 1972). But actual experience in Canada with them has been very limited. The most celebrated HMO is the Group Health Centre in Sault Ste Marie, Ontario (Hastings et.al., 1973; Willems,1976; Lomas,1985). There is nothing comparable to an HMO in Quebec.

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[1] The literature on HMOs is large, but the writings of Luft( 1978,1980,1981) have come to be a standard reference on the performance of HMOs. His results, like those of others, indicate that HMOs do provide health services at significantly lower cost. They typically have lower hospitalization rates and use careful manpower planning.

## PRICE-COMPETITION

The central problem confronting the apostles of HMOs all over North America has been finding a way to stimulate their growth. One approach receiving considerable attention in the U.S. in recent years involves restructuring the health system so as to encourage price-competition among a number of health care providers, including some HMOs (Enthoven,1978). The belief is that HMOs would thrive in competition with conventional health insurance plans.

Stoddart and several collaborators have been developing such a scheme which they think would be appropriate for at least Ontario (Stoddart and Sheldon, 1984; Muldoon and Stoddart, 1986)[2]. Stoddart has also prepared a version for the Rochon Commission. However, there has been little critical discussion of the applicability of this scheme to Canada (Evans, 1984; Horne,1984)

Although price-competition in health services is still an idea in its infancy, it seems sufficiently important to warrant a detailed analysis here. It is certainly one way that government involvement in the financing and management of the health system could be reduced, as explained in Chapter II. Thus, the focus of this chapter is on this price-competition model. At the end, however, some words will be said about other methods of introducing HMOs.

Price-competition could be structured in a variety of ways, which makes discussing it difficult. Moreover, the available proposals are really only sketches, with many important aspects yet to be specified. Thus, it is not possible to provide a detailed review of a well-developed price-competition proposal. Consequently, the analysis here focuses only on key elements. The version of price-competition presented here is similar in many aspects to that version developed by Stoddart and Sheldon(1984). Of course, some concerns expressed here may prove unfounded as the idea receives further development, and other problems may appear, too.

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[2] An earlier version of the price-competition model for Canada was offered by Blomqvist (1979).

## THE KEY ELEMENTS

### The Competing Plans

In each locality there would be a variety of competing health plans. Each plan would receive a per capita grant from the government for each person enrolled with it. Then it would finance for each enrollee a basic set of health services, including physician and hospital services, specified by the government. Each plan would be identified with one of three sectors.

There would be at least one plan in the "capitation sector". Each of these independently managed (and owned) plans might provide at least some of the required services itself; ambulatory services could be provided by physicians and other health personnel (e.g. nurse practitioners) working for the plan. Some plans might subcontract hospital services. Other plans, however, might operate their own hospitals as well as provide ambulatory services. The plans in this sector need not be just HMOs. For example, the plans could include primary care providers (Moore, 1979, 1983) and independent practice associations (IPAs)[3].

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[3] Although the IPA-styled plan itself would be paid by capitation, the participating physicians would continue to be independent practitioners reimbursed fee-for-service. For some description of a range of possible forms for these plans in the capitation sector, see United States Congress (1986), pp. 179-208.

Second, there would be a "conventional" sector comprised of a single plan, which would be structured and function much like our current health system does. Physicians would continue to be independent practitioners reimbursed via fee-for-service, though some might be in group practices. The government would also pay this "plan" the per capita grant for each person enrolled with it.

There might also be a third sector. Stoddart and Sheldon envisage that this sector would consist of a government run "experimental" plan built around CLSCs. In fact, as explained later, this sector could end up being the plan for low income families. The physicians would work directly for the plan, perhaps being paid a salary.

There are many design details that would have to be considered, but which are beyond the scope of this discussion. Should investor-owned plans be permitted in the capitation sector? Should plans be allowed to levy user charges, as Stoddart and Sheldon propose? How would highly specialized tertiary hospital and physician services be integrated into the competitive structure? How would the CLSCs be integrated into the restructured system? If they were the backbone of the "public plan", some other organization would have to be developed to provide the health and social services now provided everyone by the CLSCs to people not enrolled in the public plan. How would the hospitals be integrated into the plans? It would be very much in the spirit of price-competition that hospitals should at least compete with each other for contracts to provide services to the various plans. But it is also possible that individual plans could take-over and operate their own hospitals[4].

## The Annual Per Capita Grant

The government would determine annually the amount of the per capita grant that each plan would receive for people enrolled with it. The amount of the grant for any particular person would be the same for all plans; it would not vary from plan to plan, according to the plans' actual costs. The amount would depend, however, on the person's age and sex. If it did not, the plans would have a financial inventive to enroll middle-aged men and women, who make relatively little use of health services, and to turn away youths and older people, whose utilization of services is much greater.

There are several possible formulas for determining the grant. For example, the government could set this year's grant by adding to last year's grant an "appropriate" adjustment for cost increases and for new services. Alternatively, it could set this year's grant equal to the actual average per capita cost of all the plans last year. Or, the grant could equal the average per capita cost of the least-cost plan last year. This third formula is used in this analysis[5].

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[4] In areas where there was only one hospital, this could create a dilemma for residents, who would have to choose between the plan which controlled the local hospital or another one which would necessitate long trips, particularly for people residing in rural areas, in order to obtain hospital services.

[5] Other formulas could be used, but the evaluation would be much the same. There are a variety of technical problems, too. For example, if the grants were set by looking at the cost of the cheapest plan, there could be an additional problem if the number of people in the plan were small. Should the cost of a plan with only 50,000 members be used to determine the per capita grant for everyone? It may be necessary to base the grant on an average of some of the least cost plans.

Note that with either of the last two formulas the grant would be set "mechanically". This is an important feature of the price-competition proposals, including the model of Stoddart and Sheldon. As a result of this formula, government no longer would have any discretion in determining the amount it spent on health services[6]. The amount of taxpayers' money to be spent would be determined by the performance of the plans in the past, not by the State. The determination of government spending would be privatized! But is this feasible? Should the government provide in the per capita grant some adjustment for expected cost increases or for new services? It will be argued later that it would be very difficult for the government to avoid using some discretion when deciding about the grant each year[7].

## The Membership Fee

If a plan's expected per capita costs exceeded the per capita grant, the plan's administrators would charge each enrollee an annual "membership fee". This fee would be the difference between expected costs and the grant. It would not be a user charge, however, because the amount each person paid would be independent of his utilization of services. To the extent that expected costs varied among the plans, the amounts of the the membership fees charged by the various plans would also vary. On the other hand, if a plan had expected costs that were lower than the per capita grant, it would give its enrollees a rebate.

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[6] This assumes that the public plan would not be the least cost plan. In fact, as argued later, it may be the cheapest one, in which case government would indirectly determine the grant.

[7] To be very practical for a moment, note that it would take the accountants some time to close the books at year's end, so reliable cost data would not be available until sometime into the next fiscal year to determine the government's grant and the "membership fee", which is the linchpin of price-competition. But if last year's cost data were not used, it is hard to see how the government could avoid providing some discretionary adjustment to last year's grant.

Here there is an important design issue: should employers be allowed to finance these fees for their employees and receive a tax deduction for the cost? Ontario employers, for example, now pay their employees' health insurance premiums. If membership fees were paid by employers, it would greatly reduce the workers' concern about the cost implications of their enrollment decisions. Thus, a necessary condition for price-competition to succeed is the inability of workers to have their fees financed by their employers. But whatever happened to the tax law, given that health insurance has long been an important fringe benefit throughout North America, there would be considerable pressure on employers to pay the membership fees, directly or indirectly through "special" wage increases[8].

If a plan's actual costs proved higher than expected, it would have to finance them out of future revenues[9]. Its future membership fees would have to be higher as a result. Thus, the financial attractiveness of the plans would depend not only on their current performance, but also on their past performance. Individuals would have some financial incentive to switch plans to avoid having to pay for a plan's past deficits. However, it may prove politically impossible for the government to avoid financing some deficits; it has certainly not been able to avoid such financing for Quebec's hospitals. Of course, if the government did finance deficits, this would greatly weaken the impact of price-competition. Plans would have an incentive to set membership fees a little lower than otherwise in order to attract enrollees, expecting that the government would come to their rescue if they later encountered financial problems.

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[8] These membership fees could not be financed by supplementary health insurance because the enrollment decision would not be an insurable event.

[9] This is an environment where costly cases could create problems. For example, small plans could have some problems. If a few enrollees unexpectedly required very expensive care, a plan's actual costs would be raised, the amount of the per capita increase being inversely related to the size of the plans membership. Instead of the cost of an expensive case being spread all across the the Quebec population, as at present, it would be borne only by the people enrolled in the particular plan which provided the care.

## The Enrollment Decision

Each year consumers would enroll with one of the plans, their decisions being based on their impressions of the quality of care provided by the various available plans and their membership fees. Assessments of quality of care would depend on the information available about the features and performance record of the plans as well as on consumers' personal preferences.

Quite likely people's choices would be influenced by their incomes. People with higher incomes would certainly be better able to afford plans with higher membership fees. If the higher cost plans were able to project an image of providing better quality care and more services, higher income families would gravitate towards them. On the other hand, lower income families would probably gravitate toward the cheaper plans.

There is no guarantee that any plan would be available without cost for the poor or anyone else. If the per capita grant were based on the costs of the cheapest plan in the previous year and if costs were increasing even moderately, it is possible that all plans would have expected costs for the current year that were greater than the per capita grant. This problem might be avoided either by adjusting the per capita grant for expected cost increases or by basing the per capita grant on the average cost of a group of plans. But neither of these formulas would eliminate the effect of income on plan choice. Low income families would tend to congregate in the least costly plan(s)[10].

To facilitate consumer choice, the government might do several things. First, it might provide people with information about the plans. This could range from information about the services provided by the various plans to information about the quality of care each plan has been providing. Such information would certainly be needed to enable consumers to make reasonable choices among plans.

Second, the enabling legislation would have to guarantee people the right to enroll in the plan of their choice, and the government would have to establish a mechanism to enforce the guarantee[11]. For example, the plans would have a financial incentive to avoid enrolling (or re-enrolling) people who would be high cost patients, and to seek enrollees likely to be low cost-patients. Although the per capita grant would be higher for people 70 to 75, as explained earlier, some of these people would be more intensive users of services than others. Intensive users--the chronically ill, for example--would raise the plans' cost, so plans would have a financial incentive to avoid them.

## DYNAMICS OF PRICE-COMPETITION

### A Simple Scenario

To begin with, it is useful to employ a very simple version of the proposal to indicate some desirable features of price competition as well as some of the problems. Later a more complex version will be used to illustrate additional problems.

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[10] If the cheapest plan were to change from year to year, people who could not afford the membership charges would have to change their plan each year.

[11] There would have to be some equitable procedure, however, to deal with situations where people wanted to enroll in a plan that was already full. For example, if the other plans were more expensive, should these people be required to pay the higher membership fee?

Suppose in a small locality there were only two plans, a single HMO and the conventional fee-for-service plan. Suppose also that the latter was operated like a group practice, so that physicians had a mechnism for collective decision-making with respect to the operation of their fee-for-service plan. Finally, suppose that no new technology is developed, and prices, wages and fees are unchanged. Note that in this scenario the government plays only a passive role. Each year it pays the per capita grant, which is actually determined by the plan with the lowest average cost.

At the beginning of the first year, people would distribute themselves between the two plans for reasons unrelated to price because there would be no membership fee. In the initial year the two plans would establish themselves. The per capita grant that year might be based on the average per capita cost of services in the last year of our current system.

Given the available evidence, it is quite reasonable to expect the HMO to have lower costs than either the fee-for-service sector or the per capita grant. Thus, in the first year, even without any price-competition, the actual cost of services would be reduced by the introduction of the HMO. The extent of the reduction would depend directly on the proportion of the population that enrolled with the HMO. Henceforth, this reduction will be referred to as the "implantation effect".

In the second year, government spending would be lower than in the first year because the second year's grant would equal the average cost of the HMO in the first year, which was lower than the per capita grant in the first year. People who enrolled in the conventional fee-for-service plan would pay a membership fee from their own pockets because the average cost for that plan would be higher than for the HMO.

Consider now developments in the second year, which indicate why some people are attracted to price-competition. At the beginning of that year, the membership fee for the fee-for-service plan might cause some people to switch to the HMO. If so, the fee-for-service plan itself might become concerned about its "competitive" position and take steps to reduce its costs[12]. Such actions might also cause the HMO to seek ways to further reduce its costs.

The shift of some people into the cheaper HMO as well as any cost reductions in either plan would cause total health costs to fall again in the second year. The government's health spending in the third year would be reduced, however, only if the HMO were able to reduce its costs further in the second year. If it were not able to do this, the government's per capita grant in the third year would be the same as in the second year.

To indicate the possible complexity of subsequent competitive processes, suppose that the average cost of the fee-for-service plan were reduced more than the average costs of the HMO. As a result, in the third year the membership fee of the fee-for-service plan would be lower than in the second year. This might cause some people to move back to the fee-for-service plan.

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[12] Note that the HMO must be able to reduce its physician requirements below those in the fee-for-service plan in order that the latter plan would become concerned about its competitive position. Suppose that before the introduction of competition there was one physician for every 500 people, and that the HMO continued to use the same staffing ratio. Then if 500 people opted for the HMO, one physician would have to switch as well. The patient load for physicians in the fee-for-service sector would be unchanged, so they would have no incentive to try to reduce their costs. But if the HMO used a lower staffing ratio, as a result of different practice patterns and the use of nurse practitioners, then the supply of physicians relative to the number of people in the fee-for-service plan would increase as some people moved into the HMO. Initially, the patient loads of physicians in that sector would decrease, which would trigger attempts by the fee-for-service physicians to reduce their costs.

This simple competitive process would continue until the price differential between the two plans stabilized. This would occur when all people electing the fee-for-service plan believed that its higher cost was warranted by superior quality of care and people in the HMO did not think it was, and when the two plans were content with their respective market shares. When the dust finally settled in this little drama, both government and total health spending would be lower than they would have been without price-competition.

Of course, if the private actors--consumers, plan managers and the medical profession--thought health services had been underfunded prior to the introduction of price-competition, they would have a mechanism to eliminate the underfunding. In this case health costs might not fall after the introduction of price-competition. The HMO might use some or all of its savings to add the needed services, so its per capita costs would not fall very much, if at all. In addition, the membership fee in the fee-for-service sector might be raised to finance the needed services for people in that plan. Of course, if there were underfunding, this would be a socially desirable outcome; the additional costs would be warranted by the additional benefits[13].

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[13] The impact of all this on the per capita grant--on government spending--is uncertain. If the HMO's average cost was lower than average cost that would have existed if there were no price-competition, then government spending would still be lower. Whether this condition would be satisfied would depend on the extent of underfunding when the drama started.

## Some Complications

But the actual dynamics of the price-competition would probably be different, so the results would be different. Consider three complications, the first two dealing with fundamental aspects of price-competition. First, consumers may not be very responsive to the difference in the plans' costs. If people were not very responsive to the membership fee--if the HMO "enrollment elasticity" is very low, to use the jargon of economics--few people would move, and the effects of "price-competition" would be negligible. There are several reasons why people might not switch from the fee-for-service plan to the HMO. Many people may be quite content with their current physician, and others may dislike HMOs. Moreover, the membership fee might be so small that it was not consequential for most people. Clearly, the willingness of people to move is a key mechanism. If few move, price-competition *per se* would have no effect on costs. The cost effects, then, would be limited to the initial implantation effect[14].

In fact, the available evidence suggests that relatively few people would switch. Muldoon and Stoddart (1986), after surveying the literature, report that a number of HMO enrollment elasticity estimates can be found in the literature. The estimates range from -0.004 to -0.64, none of which is very large. The "baseline" estimate used in their calculations is -0.25, which means that if the price of the HMO dropped 10 percent relative to the fee-for-service plan, only 2.5 percent of the people enrolled in the fee-for-service plan would shift to the HMO[15]. Muldoon and Stoddart then turned on their computer and simulated the cost consequences of price-competition. Their results suggest that the cost effects would be quite small: Over 10 years, the savings resulting from price-competition *per se* would equal at most only two or three percent of health costs (see appendix for details). Given the effort that would be required to institute price-competition and the significant negative side-effects (see below), such savings would seem much too small to justify introducing this scheme.

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[14] Of course, there may be some movement between the plans for reasons unrelated to their cost differences. These are appropriately ignored in this analysis of price-competition.

[15] Some indirect results from the RAND Health Insurance Study suggest that there would be no effect (Marquis, 1984). But these results actually relate to the effect of co-insurance rates on the choice of physician, not the effect of membership charges on plan choice.

The second problem is that the fee-for-service plan may not respond by reducing costs. Instead, the plan may embark on an advertising campaign to convince people that its membership fee is fully warranted by higher quality care. Given that physicians advice carries some weight with their patients, this campaign would probably reduce the proportion of patients who switched to the HMO. And the total cost savings would be correspondingly reduced. Moreover, as explained later, these physicians might also individually elect to provide even more services to protect their incomes, again claiming that the quality of care was better[16]. Consequently, the per capita cost of services provided by the fee-for-service physicians need not fall; indeed, it could rise.

To underscore this problem, consider the reaction of consumers to an increase in the membership fee for the fee-for-service plan. If the increase were needed to finance increases in fees for physicians or wages and salaries for other plan workers, consumers would be able to judge the propriety of that. Indeed, they would probably act as a restraining force on such increases, because if enrollees thought that the increases were only going to enrich the physicians and other workers, some of them likely would not hesitate to switch plans[17].

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[16] The basic mechanism would be the same here as in the case of deterrent charges. Because consumers depend very much on their physicians to guide their utilization of health services, physicians are in a good position to provide more services if they want to do so. Moreover, the physicians may not only claim that another office visit would improve the quality of care, but also they may believe that it does.

But it is not clear that consumers would provide a comparable restraint on cost increases for new services. It would certainly be much harder for consumers, who are inherently ignorant of medical matters, to evaluate the propriety of fee increases for new services than for fee increases for wages. If the plan's physicians claimed that the new service would improve the quality of care, most people would accept that judgment, unless there was strong countervailing evidence. If a plan announced that it was going to add $10 to its membership fee this year so that it could buy a much needed chorographic ultra-sound machine, would consumers, who know so little about medical matters, offer much resistance? There is little evidence, in fact, indicating that consumers do act as much of a brake on physicians who want to add a new service.

Moreover, judging from the U.S. experience, the HMO probably would not create any competitive problems for the fee-for-service sector. The rate of diffusion of new services has apparently been about the same in the HMOs as elsewhere in the U.S. health system (U.S. Congress, 1986). Several researchers have reported that the rate of increase in costs during the past 15 years have been about the same for HMOs as for conventional health insurance plans (Luft,1980; Newhouse et.al.,1985). Actually, as the simple model used here makes clear, there is no reason for the HMOs to shy away from new services. With the enrollment elasticity being so low, as long as the average cost of the HMO is less than the average cost of the fee-for-service sector, the government would fully finance it; there would be no membership fee for the HMO's members.

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[17] Of course, if incomes where increasing by the same rate in the HMO, there would be no such competitive pressures restaining the fee-for-service sector.

Thus, price-competition could facilitate a higher rate of increase in health spending for new services than is occurring under present arrangements or is warranted. It would simply be a way for the providers of services currently complaining about underfunding to generate private finance for new services. Government approval of the new services would be unnecessary, and the funding would be easily obtained via a higher membership fee and a higher per capita grant. But, as explained in Chapter V, this would probably result in increased costs unwarranted by real improvements in people's health.

Moreover, if the HMO adopts the new services as fast as the fee-for-service plan, both government and total health costs could rise faster under price-competition than is warranted, too. Indeed, the rate of inflation of health costs could prove alarming. In this simple model the mechanism controlling the rate of increase in health costs seems very weak. The only constraint on the HMO would be that its costs remain below those of the fee-for-service sector. The only constraint on the latter would be its ability to get people to pay the enrollment fee, and this fee-for-service plan would be able to influence people's perceptions of the value they were getting for their money.

The third complication is the possiblity of collusion between the two plans. Other markets where there are only two sellers are usually not characterized by economists' beloved pure competition; the firms' best interests are sometimes better served by some sort of collusion. La Corporation professionelle des médecins du Québec could become either a forum for collusion or a battleground for professional struggles between physicians working in the two plans.

## Some More Complications

In a larger metropolitain area the situation would be more complex. There would be several HMOs, each with its own membership fee. In the fee-for-service plan there would be too many physicians for them to be guided by collective decision-making as in the simple scenario. A brief analysis of this situation indicates that there are additional reasons for doubting that price-competition would have much favorable effect on the average cost of the fee-for-service plan.

In this environment the single practitioner would have little incentive to take steps to reduce his costs. Perhaps he could improve his situation a little by making himself more readily available to his patients or by relating better to them. But if he reduced his costs, it could easily harm him. Eliminating some "unnecessary" services, for example, would reduce his income. Moreover, because he would be only one of many physicians in the fee-for-service plan, the change in his practice habits would have only a small effect on the plan's costs. Even if that effect did cause a few more people to remain in the fee-for-service plan, they would not all come to him. There is certainly nothing in the price-competition model that would direct patients to more efficient physicians in that sector. Because all people enrolled in the fee-for-service plan would pay the same membership fee, there would be no incentive for them to seek-out such physicians. For the individual practitioner, a better strategy would be to do nothing, and hope that all other physicians improved their performances.

An even better strategy for him would be to provide more services to the reduced number of people knocking at his door. This would be something concrete that he could do to preserve his income[18]. But from a social perspective, such behavior could be counter-productive.

There would also be some incentive to engage in some group activity to offset the competition. La Fédération des médecins omnipraticiens du Québec (FMOQ) et la Fédération des médecins spécialistes du Québec (FMSQ) could provide leadership. Certainly the FMOQ played an important role in helping some general practitioners set-up "poly-clinics" in the early 1970s when the new CLSCs offered general practitioners some competition. But how much impact could the federations have on the individual physicians' practice patterns? Would their main tool for responding to the HMOs be advertising, in which it was claimed that the fee-for-service plan provided better quality care?

Even more interesting, the fee-for-service plan might prove quite unstable. As the old expression goes, "if you can't beat'em, join'em". Consider some physicians whose practices cost less per patient than many of the other physicians' practices in the fee-for-service plan, either because they were more efficient or because their patients were not intensive users of services. Such physicians would have some incentive to form a group and move into the capitation sector. This group would be paid on a capitation basis, though the individual physicians could continue to be paid fee-for-service[19]. This would certainly be attractive to their patients, who would have a lower membership fee to pay as a result of the shift into the capitation sector. Moreover, leaving the fee-for-service plan would not mean leaving their physician.

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[18] Note that his patients would not be penalized by this strategy. The increase in the services they received would have no appreciable effect on their membership fees.

[19] Some hospitals might also provide some leadership and organize some groups to facilitate such changes. The HMOs would reduce hospital utilization, so the hospitals would also have some incentive to get involved.

But it might not reduce health spending very much. If the physicians changed their behavior once in the capitation sector, this would result in lower costs. But, because they were already low-cost practitioners, any cost savings would probably be small. The elimination of some low cost practices from the fee-for-service plan, however, would nudge upwards the average cost of that plan, and the people remaining in it would have higher membership fees.

## Summary: Effects on Health Costs

Thus, it is very difficult to predict the effects of price-competition on health costs. It seems reasonable that the capitation sector would have lower average costs than the fee-for-service sector; this would yield some savings, the magnitude of which would be directly related to the fraction of the population opting for capitation. It appears, however, that price-competition *per se* is not a very strong force luring people into HMOs. Moreover, it is not at all clear that price-competition would significantly lower average costs in the fee-for-service sector; indeed, it could actually allow them to rise. Thus, it is even possible that total health costs could rise, not fall as a result of price-competition.

Costs may rise rapidly in both the capitation and fee-for-service sectors in an environment in which attractive new technologies are constantly appearing. The American HMOs have not been able to restrain their health cost increases any more than the private insurers have. And with government in this version of the competitive scheme having only a passive role -- merely paying the per capita grant, which would actually be determined by the least-cost HMO -- the cost trends in Quebec could prove alarming. What this implies, of course, is that government could not play a passive role, at least not for long. With justification, it would seek some way to control the rate of increase of the per capita grant. A possible control mechanism will be discussed in a moment.

Evidence is only beginning to appear in the literature with respect to the cost implications of competition in the United States. But the most recent appraisals certainly do not suggest that price-competition is a powerful antidote for high health costs. After analyzing data for 25 urban areas, Merrill and McLaughlin (1986) report that hospital costs in an area seem unrelated to the fraction of the population which belongs to an HMO. Luft et.al. (1986), Johnson and Aquilina(1986), and Feldman et.al. (1986) make detailed studies of the impact of competition in particular localities (e.g. Minneapolis, Minnesota) where competitive pressures have often been thought to be strong. The available evidence, these researchers conclude, does not demonstrate that competition has, in fact, had much impact on health costs. These are not highly polished, definitive studies. But if price-competition really was a strong force causing significant cost reductions, the effects should be apparent in some of these studies.

Thus, researchers keep searching for evidence that price-competition would reduce health costs. But it is important to remember that for price-competition to be socially desirable, there must be not only cost savings, but also savings which are large enough to warrant the fuss and bother associated with introducing price-competition as well as the negative side-effects described below.

The available evidence does not suggest that people in any significant numbers would respond to cost differences and seek-out lower cost plans. Perhaps the movement of physicians into the capitation sector, bringing their patients with them, would be more consequential than the price-effects on the consumers themselves. Would it be possible to encourage practitioners to move into HMOs or comparable organizations without even resorting to price-competition?

## THE ROLE OF THE STATE

### Determination of the Per Capita Grant

Even with price-competition, the State would remain deeply involved in the financing and management of the health system. Certainly, one important form of this involvement would be its annual determination of the per capita grant. There is no reason to expect that this would be a "mechanical" process; the government would have as much discretion in setting the grant as it currently has in setting hospitals' budgets.

At this point, it is important to introduce the third sector, the public plan, into the analysis. This plan would quite likely prove to be the cheapest one, so its per capita cost would determine the per capita grant. Thus, the government's decisions about the operation of the public plan would shape the per capita grant for everyone.

The government would certainly find it attractive to be parsimonious with respect to the public plan. This would keep down its costs not only for the public plan, but also for the per capita grant. As suggested above, unless the government itself controls the rate of increase in the per capita grant, the inflation of health costs could prove quite unacceptable. An easy way for government to control the rate of increase of the grant is by basing the grant on the cost of the public plan.

Parsimony would be politically attractive, as well. There is obviously much pressure now on the government to find ways to keep down its spending. Moreover, because low income families, who have little political clout, would likely be the primary constitutents of the public plan, the government efforts to limit spending on the plan would not be very costly politically.

There could be one possible countervailing force, however: the lower the cost of the public plan, the greater would be the membership fees for the other plans. Thus, the middle class would be concerned that the government not squeeze the public plan too much. But this mechanism should not offer too much comfort to people who think the health system is currently underfunded, even though all Quebec residents currently have a direct stake in the government's financing decisions. There is certainly no reason to think that the political pressures under price-competition would be sufficiently greater that the public plan would be more amply funded that the present system is!

There is another reason for government continuing to have discretion. Whichever plan is the cheapest in the current year, next year's grant would have to include some allowance for expected wage and price increases and, perhaps, even for new services. It is unreasonable that--when all the plans were expecting higher costs because of higher wages, fees and prices--

government would make no allowance for such increases when determining next year's grant. To make no such allowance would have undesirable financial implications for the plans[20]. Of course, the government would have some discretion in deciding how much allowance to make for wage and price increases. Perhaps the simplest way for the government to determine the per capita grant for next year would be to base it on the expected costs of the public plan for next year.

It might appear desirable that no adjustment be made for the cost of new services; new services then would be publicly financed only when they had been implemented by the least cost plan. This might slow the diffusion of questionable new cost-increasing technology. But, as already noted, it is doubtful whether consumers could act as much of a brake on physicians who wanted to add a new service that they think is desirable. Moreover, if making no adjustment for new services would slow the diffusion of undesirable new services, it would presumably have the same effect for desirable ones, too. Finally, if government financial support for new services were slow in coming, their diffusion might have a distinctive pattern. New services might tend to be introduced first in the high priced plans, which attract families with high incomes, and last in the low priced plans, which attract families with low incomes.

Note that the willingness of the government to pay for hospital wages and physicians' fees would continue to have considerable influence on the outcome of collective negotiations. As in the past, then, the government would continue to shape health cost trends by the deals it makes at various bargaining tables.

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[20] If no allowance were made for the wage and price increases, the plans would either have to find a way to absorb the increase or have to raise their membership fees. There are limits, of course, on how much could be absorbed. Moreover, if all plans were expecting comparable increases in wages and fuel prices, there would be little competitive pressure on them to contain their costs; no one could move to another plan to avoid the cost increase. Note also that if all plans were forced to charge membership fees to cover expected cost increases, there would then no longer be any "free" plan for low-income families.

Parenthetically, price-competition would have a variety of other important implications for collective bargaining. Would province-wide negotiations for hospital wages continue? Would hospital-by-hospital negotiations be reasonable? It could certainly put the workers in an unreasonable situation. On the one hand, if the hospitals were competing for contracts from the various plans, they would be looking for ways to keep down their labour costs. On the other hand, the workers' ability to defend their interests has been sharply curtailed by the recent Quebec legislation effectively banning strikes in the health sector. There are other issues, too. For example, would each competing health plan be able to negotiate separately with its employees? What would be the impact of settlements elsewhere in the public sector? Would there be separate negotiations for physicians in each of the three sectors?

## Consumer Protection

The State's direct involvement in the competitive structure would extend beyond setting the per capita annual grant. It would need to develop administrative mechanisms to prevent plans from discriminating against people for one reason or another. This issue is discussed in more detail later.

There would also be a need to provide consumers with information about the plans. In order for consumers to make reasonable choices, they would need better information than is presently available. Would government provide them with useful information about the quality of care provided by the various plans[21]?

## Involvement in the Fee-for-Service Sector

The extent of government involvement in the the fee-for-service sector is unclear. There are several possible scenarios, one's preference depending on one's judgment about the ability of price-competition to make this plan function in a socially desirable way. If one thought, for example, that price-competition would provide an effective brake on cost increases, then little government involvement in the management of this plan might be needed.

But, if--as seems more likely for reasons already presented--the competitive structure would result in excessive cost increases, then some government involvement would be warranted. What form would it take? Would its involvement be very different from its involvement in the management of Quebec's current plan? Would it negotiate fees and wages? Would it approve hospitals' budgets? Would it take steps to overcome access problems caused, for example, by the regional mal-distribution of physicians?

## Shaping the Environment

Finally, the government would shape the environment in which the competing plans functioned. For example, it would prescribe the minimum benefits each plan had to provide. It would also determine the extent to which the plans could engage in manpower substitution. This could be an important source of savings (Lomas and Stoddart, 1985; Spitzer, 1984). But would the government compel la Corporation professionelle des médecins du Québec to allow physicians to use nurse practitioners? How would services rendered by nurse practitioners be financed?

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[21] The problems here are obvious. How up-to-date would the information be? How would government measure "quality of care"? The existing information sources do not facilitate providing meaningful information about quality of care. Would government report utilization rates or cure rates? What is politically feasible? What sort of protection would be offered providers against errors? The task would be further complicated by the multiplicity of plans.

In addition, a policy would have to be developed regarding entry into the health system. Presumably new plans would be allowed to enter the capitation sector. But would they be guaranteed access to hospital services? Moreover, what sort of policy would the government take towards new physicians? HMOs would certainly not be obligated to hire all new physicians looking for work[22]. But, what would be the policy with respect to new physicians entering the fee-for-service sector? Quite understandably, in a competitive environment the existing physicians might be reluctant to have physician numbers continuing to grow. Would government take steps to slow the rate of increase in physician numbers?

Finally, government would continue to be responsible for technology assessment. As explained in Chapter X, it is doubtful that any single plan would undertake much evaluation of new services.

Note that government could take the necessary steps now to facilitate manpower substitution, restrict the flow of new physicians into the health system, and sponsor more evaluations of health technology. None of these steps require price-competition. As explained in Chapter X, if government took these steps now, the performance of the health system would probably improve. By how much more would it improve if price-competition were also introduced?

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[22] This would not preclude some new physicians from starting their own HMO or comparable organization in the capitation sector.

## Price-Competition and Privatization

Price-competition would involve two forms of privatization. First, the membership fees would shift part of the cost of health services from the government to private individuals. Even if very few people were in the cheapest plan, government health spending would be lower as long as the average cost of the cheapest plan was less than the average total cost of health services[23].

Second, with price-competition some managerial responsibilities would be shifted from the State to the individual health plans. But the extent of this shift could not be as great as many proponents of price-competition imagine. According to the simplest versions of this scheme, the government would move to the sidelines. But this is unrealistic. As just indicated, government would remain a very active participant. Among other things, cost pressures would compel it do so.

Thus, unless it were thought that current public decision-making processes really could not be improved--a view that would be very hard to defend--there is a need to improve these processes, whether or not price-competition is introduced. This theme will be developed further in the next chapter.

## CONSEQUENCES FOR USERS OF THE SYSTEM

Competition would have some attractive features for consumers. They might have better information about the providers of care. Certainly people choosing a physician now have little "objective" information to guide them. Consumers would also have a greater choice of care modalities. HMOs provide a different type of care than conventional fee-for-service practice does, which at least some people appreciate, judging from the U.S. evidence[24].

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[23] More precisely, the condition is that the per capita cost of the cheapest plan be less than what the average cost of health services for the entire population would be without price-competition. It is quite plausible that this condition would be satisfied.

Stoddart and Sheldon also argue that price-competition would be consistent with important goals that have guided health policy. Certainly, everyone would continue to have access to all medically necessary physician and hospital services. But price-competition would be incompatible with other important features of our present system.

### Equity in Access

It seems quite reasonable to suppose that income would influence plan choice. People with high incomes would gravitate towards the more expensive plans, and people with low incomes towards the cheapest plan(s). If there were a government operated "public plan", it would probably prove to be the cheapest plan. As already explained, there are strong financial pressures for this to happen, and weak political pressures to prevent it. Moreover, if the public plan is *perceived* as being the plan for the poor and of inferior quality, people who could more readily afford to pay the membership fee for one of the other plans would go elsewhere.

Thus, there is little reason to think that low income families would receive the same care as other people. Certainly anyone familiar with the quality of care provided in the U.S. to low-income people "fortunate" enough be covered by the American Medicaid program and receiving services in municipal and county hospitals and from physicians at reduced rates realizes that congregating the poor in one plan would result in their receiving inferior care[25].

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[24] Given the sources of care currently used by many people, being funneled into a particular plan would be quite a change for some people. Many low income families are very dependent on hospital emergency rooms for care, for example (Siemiatychi et.al., 1980). They would presumably receive their primary care services elsewhere if price-competition were introduced. What would be the consequences of this change itself for them?

This problem could not be avoided by eliminating the public plan from the scheme. Low income families would likely congregate in the cheapest plan, whether or not it were government operated. Moreover, the problem could not be completely avoided by providing low income families with special subsidies. There would certainly be administrative problems. Who would be eligible? When user charges were introduced in Saskatchewan in 1968, only people on welfare were eligible, but they were by no means the only people with low incomes (Beck, 1974). Would all those who were eligible make use of the special grants? In Ontario, for example, many low-income people who are eligible for reduced health insurance premiums apparently do not use them (Canada, 1981). Moreover, the size of the grants would be a problem. Should it equal the highest membership fee, allowing the poor access to any health plan? Unless it did, all residents of Quebec would not have equal access to health services.

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[25] For example, The New York Times (17 February 1987, p. A14) carried a story indicating that pregnant women on welfare in a particular area of Rhode Island might soon be unable to get prenatal care--unless they were willing to endure a long, uncomfortable bus ride to a teaching hospital affiliated with Brown University. Two obstetricians in the area were already refusing to see them, and the remaining three were seriously contemplating refusing them, too. The problem: Medicaid only pays the doctors $350 for obstetrical care, while private patients pay between $1250 and $1400.

If the subsidy were provided in cash, the way the money was actually used could also prove to be an issue[26]. Low income families might understandably still opt for the cheapest plan(s), and use the cash for purposes other than for purchasing health services. From the point of view of the family, this would be the best way to use the money. But from a social perspective, this might be viewed as an undesirable sacrifice of health for other things. It is no accident that society has preferred that health and welfare programs be kept separate.

As explained in Chapter IV, a key concern about extrabilling is that it might result in a two-tier health system. But a competitive structure would be a two-tier (or even a multi-tier) health system, providing one standard of care to the non-poor and a lower standard to the poor. Thus, price-competition is incompatible with the important principle of equity of access.

The poor, of course, would not be the only people of special social concern affected by price-competition. How would the aged be affected? Would price-competition lead to the fragmentation of geriatric services among a variety of plans? Perhaps, one or two plans might specialize in the care of the chronically-ill aged. Or perhaps a special supplementary program would have to be organized for them. What would be the implications of competition for people in rural areas? Would competition resolve their current access problems, or would it make them worse? Outside of the larger urban areas, it is not clear that competition would be feasible. The people are too few and the distances often too great. If multiple plans were sustainable there, would many people have to travel greater distance than they do now to obtain services from their plan? If there was only a single plan, would it be the likely inferior, though cheaper government operated plan? If it were the fee-for-service plan, would rural residents have to pay a membership fee?

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[26] One way to do this would be to give an actual cash grant to low-income families. Another way would be to base the per capita grant on the average cost of all plans, thereby giving poor people a greater range of plans from which to choose. If a low-income family opted for a plan with below average costs, it would receive a cash rebate.

## Bureaucracy

Using the health system would inevitably prove more difficult for some people from all walks of life because price-competition would necessitate more complicated administrative structures than Quebec's present arrangements do. A major advantage of our present financing arrangements is their simplicity. People are always covered for all services wherever they obtain them in Quebec, so people now can obtain health services with no bureaucratic fuss and bother. This is an important reason why our present arrangements are so popular with the non-poor as well as with the poor (Soderstrom, 1983b). To see how this would change with competition, consider three examples.

First, if someone becomes unemployed now, their access to health services is unaffected. But what would happen if someone became unemployed and no longer able to afford the membership fee of the plan in which he was enrolled[27]? Many people's economic situation changes for reasons related not only to unemployment, but also to death in the family, marital break-up, bankruptcy, etc. Some bureaucratic mechanism would be necessary to deal with such problems. Similarly, there would also have to be a bureaucratic mechanism to aid people who move within Quebec during the year and have to change plans. Bureaucracy, however, inevitably means that some people would get caught in bureaucratic red-tape and have problems obtaining services.

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[27] Unless the membership fee were negligible, it would be unreasonable to expect that it would be paid on a yearly basis by everyone. Many people would probably prefer to pay it on a monthly or quarterly basis.

Second, as already noted, a special bureaucratic mechanism would be needed to protect people and the plans. For example, as explained earlier, the plans would have a financial incentive to avoid people with chronic health problems. One way to deal with this problem would be to adjust the per capita grant for differences among people in their expected utilization of services. In practice, this is hard to do. Adjustment could easily be made of differences related to age and sex. But there would still be enough variation in utilization among individuals that plans would find it financially advantageous to discriminate against some and in favor of others[28].

Thus, some administrative mechanism would be needed to protect people[29]. This mechanism would have to be expeditious and effective, so as not to burden unduly the sick. Unfortunately, the enforcement machinery that exists in other areas of social concern--minimum working conditions, wage decrees, human rights and youth protection--have proved neither expedious nor always effective.

Finally, if people used hospital or physician services aside from those provided by their plan in which they were enrolled, they would have to pay the cost from their own pocket. This would introduce a new element into billing practices here. To what extent would this bureaucratize hospital admissions and physician office visits?

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[28] In one US study, for example, Medicare expenditures for each beneficiary were related to the beneficiary's age, sex and welfare status. These variables could account for only 0.6 percent of the variation in expenditures among beneficiaries (U.S. Congress (1986): p. 190).

[29] The importance of this mechanism would be increased if la Corporation professionelle became paralyzed by conflict among physicians from the different plans, as suggested earlier.

Note that the size of these problems would be directly related to the number of plans that existed in a locality and across the province. If, as argued above, the fee-for-service sector proved unstable under price-competition and the number of plans in the capitation sector grew, bureaucratic problems would grow as well.

## Consumers' Ability to Evaluate Competing Plans

Certainly an important aspect of the competitive structure would be the ability of people to make reasonable judgments about the quality of the competing plans. But can they? The assessment of quality of care is a very difficult thing. Quality is not something that is self-evident or that can be easily revealed by a little testing by the Canadian Standards Association as with a new model of a toaster. Note this information problem would also increase in proportion to the number of plans.

The ability of consumers to make more meaningful judgments than are now possible would depend greatly on the quality of information provided by government and the competing plans. What sort of information would government provide? As already indicated, it is doubtful that government would provide a great deal of substantive information. What sort of information would the plans provide? There is good reason to be concerned that providers in the fee-for-service sector would rationalize current practice patterns as constituting high quality care[30]. One man's waste is another man's quality? Given consumers' ignorance of technical medical matters, these plans would be in a good position to convince consumers that their quality is superior.

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[30] This is not to say that the providers would behave like used car salesmen. Many are quite comfortable making such arguments because they do believe they are providing high quality care.

The point here is not that people should not have more information about quality of care. Rather, it is that such information is difficult to acquire. Consequently, one should be wary of building an entire health system on the presumption that people would be reasonably well-informed, and wary of claims that people's well-being would be significantly enhanced just because some people would make different choices than they now make if the system were organized differently [31].

Of course, people would make better decisions if more reliable information about the quality of care were available to them. People themselves would make different decisions, and it would affect their attitudes toward government health policies. But if better information is beneficial and feasible, it obviously could be made available without introducing price-competition. Why not make it available now? Before any price-competition scheme is tried, the feasibility of providing people with much better information about the quality of care they are receiving should be demonstrated. It would be very interesting to see what would happen if it were disclosed that certain Montreal physicians and hospitals were providing poor quality care. The ensuing ruckus would certainly be far more entertaining than Expos baseball.

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[31] For example, consider two surgeons (or two plans) which have quite different surgical success rates. If we were omniscient, we would know whether the difference is because the more successful is more skilled or because the less successful deals with much more difficult cases. But is it actually possible and practical to provide consumers with the information needed to determine whether the surgeon (plan) with the higher success rate actually was providing better quality care? It is doubtful (Schroeder, 1987). But then the decisions made with price-competition are not necessarily better than those being made now--different decisions do not necessarily mean greater efficiency. One may start groping blindly upwards after having long groped blindly downwards, but that does not necessarily mean that one is getting closer to nirvana--which actually happens to be two feet behind.

## PRICE-COMPETITION: CONCLUDING OBSERVATIONS

Although there has been much discussion of price-competition in the U.S., there has been almost no discussion of it in Canada, let alone in Quebec. But it is doubtful that price-competition would eliminate the health spending controversy in Quebec. It would have significant negative side-effects, moreover. Thus, one should be very wary this proposal at this time. The key question now is how much time and treasure should be devoted to the further development of this idea.

### Negative Side-Effects

Price-competition would re-introduce some barriers to access that our present financing arrangments were orginally introduced to overcome. Equity in access would be undermined because the choice of plans would be income dependent; price-competition would quite likely result in at least a "two-tier" health system. It would also bureaucratize access to some extent. Thus, price-competition is not consistent with important principles which underlie current arrangements, and which no one has been openly arguing should now be caste aside.

### Impact on Health Costs

Government health spending would be reduced. The government per capita grant would be based on the average cost of the lowest cost plan, so its direct spending on services would be reduced. Of course, the increased administrative costs associated with the competitive structure would reduce this savings somewhat. This saving could be a seductive lure for a government pre-occupied with reducing government spending, no matter what might be the effects on total health costs and the well-being of Quebec society.

It is less certain that total health costs would be lower. Private individuals' spending on membership fees would have to be added to the amount of government spending to determine the total cost. It is certainly possible that the spending on these fees would be sufficiently small that the total cost of health services would be lower with competition than under present arrangements. But it is also possible that the force of competition would be too weak to constrain the fee-for-service sector. Providers have been complaining about underfunding, so they might well set large membership fees in order to provide themselves with additional revenue for higher incomes and more new services. Some of the new services might be warranted, others not. Thus, if government did not intervene, costs might climb considerably in this sector. Whether the increase would be sufficient to offset the savings yielded by the HMOs cannot be determined except throught actual experiences.

### Role of Price-Competition

It is certainly not obvious that price-competition *per se* would be the active ingredient promoting social welfare in the competitive structure. Any cost savings associated with competition may have little to do with price competition. As already indicated, a competitive structure has two key elements. The first is different modes of providing services. The simplest version would have a fee-for-service mode and an HMO mode. The second element is price-competition itself, which is supposed to give people a financial incentive to opt for the lower cost HMO mode, and, thereby, to give the providers in both modes some incentive to operate efficiently.

The available empirical evidence, however, does not suggest that price-competition *per se* would have much beneficial impact on total costs. The evidence relating to the enrollment elasticities suggests that consumers' sensitivity to the price differences of competing plans is not very great (Muldoon and Stoddart, 1986). Consequently, the resulting cost savings even for government would be very small. Moreover, researchers in the U.S. are still searching for evidence that price-competition there has much of any effect (Merrill and McLaughlin, 1986; Luft et.al., 1986; Johnson and Aquilina, 1986; Feldman et.al. 1986)[32].

Thus, whatever cost-savings are possible from a competitive structure could probably be obtained by stimulating the development of HMOs without adding the apparatus of price-competition. Indeed, if the enrollment elasticities are as low as they appear to be, almost all of the cost reduction associated with competition would actually be caused by the implantation of HMOs[33].

It is also interesting that the negative effects of the competitive structure are largely the result of price-competition *per se*, not the existence of HMOs. Equal access would be undermined by the membership fees, not by HMOs. The extent of the bureaucratization of access would be reduced if membership fees were not involved. Price-competition might generate somewhat greater variety in delivery modes, but just the existence of several large HMOs in the Montreal area would provide a substantial increase in diversity relative to the current situation.

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[32] But even if the American experience did suggest that competition was desirable there, that would not necessarily imply that competition was desirable here. The state of Quebec's health system in 1987 is very different from that of the American system. We have much less waste and higher standards with respect to equity in access.

[33] Certainly in the simulations reported by Muldoon and Stoddart, almost all the cost savings were due to their existence; making allowance for the price-competition effects added very little.

Of course, the improvement in system performance would be directly related to the proportion of the population which opted for HMOs. How could people be encouraged to opt for them? Price-competition would provide them with a financial incentive. But the foregoing analysis implies that it is an ineffective stimulant, and that it has some serious negative side-effects as well.

## HMOs: ANOTHER LOOK

There is insufficient space here to present a detailed blueprint here for developing HMOs in Quebec[34]. But their implantation seems feasible. For example, community groups could be encouraged to form HMOs. Groups of physicians and hospitals could also be encouraged to develop them. Perhaps, some CLSCs could be transformed into HMOs, too[35].

It should not be too difficult to find a practical financing formula for them. For example, the government might initially provide them with a per capita grant equal to some fraction of the per capita cost in the conventional fee-for-service sector[36]. This fraction should be large enough that the HMOs would be able not only to supply basic hospital and physician services, but also to share in some of the savings from its greater efficiency. The HMOs could use the savings to provide additional services to their enrollees. The conventional fee-for-service sector would continue to function just as it does now.

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[34] The most useful thing to be done now would be to organize a number of small committees to prepare protocols for developing several HMOs. Perhaps several groups could be invited to submit proposals to a juried competition, the two or three winners being given an opportunity to organize experimental HMOs. The government would have to provide these groups with some seed money, allowing them to consult widely with people experienced in organizing and managing HMOs.

[35] Le Groupe de travail has recommended that HMOs be introduced. But it provides no details about the form these HMOs should take. There are a variety of possibilities. Thus, the version supported here may not be the version that Le Groupe de travail had in mind.

The bigger problem is finding a way to stimulate the growth of HMOs. There are several possible mechanisms. One conventional lure is convenience and quality. For example, if an HMO could provide ready access to services on weekends and in emergencies, many people might find it attractive. Moreover, if the HMO provided a broader array of services than available in the fee-for-service sector, this would also attract some people. But, judging from the U.S. experience, this mechanism is not sufficient to stimulate their rapid growth.

Secondly, physicians could be encouraged to form and join HMOs. There are a variety of ways this could be done. For example, physicians could be lured into HMOs with financial incentives. There is some evidence that many Quebec physicians would seriously consider a method of remuneration other than fee-for-service (Pineault et.al., 1985a). Thus, for example, HMOs could pay salaries. If the salaries were significantly higher than the incomes many physicians could earn practicing fee-for-service, many physicians might find HMOs an attractive place to practice, particularly if the facilities and management of the HMOs were well-structured. Hopefully, established physicians opting for an HMO would bring many of their existing patients with them. Many people might be willing to join an HMO if they could do so without having to change their physician.

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[36] Actually, the grant might equal the average cost in the fee-for-service sector (adjusted at least for age and sex differences in utilization). If government squeezed the traditional sector a little financially, there should still be ample resources for HMOs to thrive. This might be one way to stimulate the growth of HMOs.

Finally, the government could provide various carrots and sticks to stimulate the development of HMOs. For example, it could provide organizational grants for groups that wanted to start HMOs. It could also widely advertise their potential benefits, and encourage people to join them[37]. In addition, government could give HMOs "special" status, allowing them to do things that the fee-for-service sector could not do. If there were serious interest in a new service, for example, the HMOs could be given access to it first. Indeed, Fred Griffiths, the long-time Executive Director of the HMO at Sault Ste Marie, Ontario, has indicated that there are a wide variety of useful things--large and small--that government could do to facilitate the growth of HMOs (Griffiths, 1984).

The magnitude of the cost savings would depend on the number of people enrolled with the HMOs, their actual operating costs and the cost-sharing formula used. Moreover, the impact on total costs would also depend on the reaction of the fee-for-service sector. If it tried to compete by improving its quality of care, society would obviously gain. The government would presumably prevent it from raising its costs above those that would occur without the development of HMOs.

But it would be a mistake to view HMOs as the solution for all the problems of Quebec's health system. There would probably only be a small fraction of the population enrolled in the HMOs in the first few years. Even in the U.S. only 8 percent of the population belonged to an HMO in 1985, despite all the interest in them for the past 15 years (Tarlov, 1986). It would certainly be a mistake to let the fee-for-service sector continue to function without attempting to improve its performance, too. The development of HMOs would complement some of the other things that need to be done (see Chapter X).

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[37] Certainly all the negative publicity about smoking in recent years has contributed to the reduction in smoking. Would comparable positive publicity on behalf of HMOs stimulate their growth?

## Private HMOs

There is still another variation on the HMO theme, the private HMO. In this scheme the HMO would be allowed to charge a membership fee. The provincial government would give it a per capita grant, which would be a fraction of the per capita cost in the conventional fee of service sector, perhaps 80 percent. Then, the HMO would charge a membership fee to generate any additional revenue that it needed.

There are two fundamental problems with private HMOs. First, though much government effort would be required to develop them, they would not significantly improve the efficiency of the system. Only a few people would be able to use them. Moreover, they could easily become havens for some physicians who think the system is currently underfunded; forming a "private" HMO would be a way to enhance their incomes and their access to various new services.

Second, private HMOs are inconsistent with the social values which underlie current health policy in Quebec. The basic problem is that their development would usher in a two tier health system, as would extrabilling and price-competition. Access to such an HMO would be income related. High income families would be able to afford the membership fee much more easily than lower income families. The political dynamics would also be undesirable. Many concerned, influential people might well find it easier to join a "private" HMO than to work on government to improve our present system. As a result, pressure on government to improve the public system would be reduced.

## Appendix:
## SOME SIMULATED EFFECTS OF PRICE-COMPETITION

Muldoon and Stoddart(1986) have simulated the cost effects of price competition. The results used here are from their scenario which yielded the largest savings (see their Table 8). That scenario is very similar to the "simple scenario" used here in the main text. In their model the HMO has the lowest cost, so the per capita grant is based on the HMO's costs.

For their simulations these researchers have in mind a small town of 80,000 people, half of whom are initially enrolled in the HMO. They then calculate the present value of the government's savings over the next 10 years that would be generated by price-competition (using a social discount rate of 10 percent). Their results are tablulated below:

| Enrollment Elasticity | Change in Share of Pop. Enrolled in HMO | Cumulative Savings to Government | Cumulative Community Health Costs |
|---|---|---|---|
| Low (-0.004) | +0.07% Pts. | $20.5 M | $144.8 M |
| Baseline (-0.25) | +4.13 | 22.0 | 143.4 |
| High (-0.64) | +10.56 | 24.2 | 141.4 |

Source: Muldoon and Stoddart (1986), Table 8.

Note that the cumulative savings to government refer to the estimated savings resulting from having both the HMO and price-competition. Muldoon and Stoddart do not indicate what the savings would be if there were no price competition. But the "low enrollment elasticity" is so small that it is effectively zero. Thus, this case is used here as the reference, indicating what would happen if there were no price competition.

The simulation results suggest that price-competition would have little effect on health costs. According to the results derived using the baseline enrollment elasticity, over 10 years price-competition would only cause an additional 4 percent of the population to enroll in the HMO and yield an accumulated savings to government $1.5 million--only a 1.1 percent percent reduction in health costs. If the computer program is rerun using the highest enrollment elasticity, the savings are only $3.7 million, 2.6 percent of health costs.

Although it is not tabulated above, Muldoon and Stoddart report that if in the initial situation only 5 percent of the population were in the HMO, the accumulated savings due to price-competition would be $2.7 million, which is still not a very large savings.

Note that the savings tabulated above only refer to the savings of government. The reduction in total costs would be smaller. An important reason for the government savings is that some health costs are shifted to private individuals in the form of membership fees for the fee-for-service plan; when the total costs are determined, these fees would have to be included.

# Chapter X
# PRIVATIZATION: SOME REFLECTIONS

This chapter begins with a brief summary of the evaluations of the privatization schemes reviewed in the preceding six chapters. Then, it is argued that privatization would not resolve some major problems because these are problems that no one would reasonably expect privatization to cure. The need for more technology assessment and manpower planning are used to illustrate this point. Toward the end, it is also argued that, though most forms of privatization are not worth adopting, it is worth adapting some features of these proposals to the Quebec system.

## SUMMARY OF EVALUATIONS

### User Charges

Quebec society would be harmed by user charges for physician or acute care hospital services. The cost of health services would be higher, not lower. Some people's health would probably be adversely affected. And, user charges would undermine the social goals of equity in access and equity in finance. Thus, social welfare would be reduced if user charges were introduced. This is true whether they took the form of a conventional deterrent charge, a tax-based deterrent charge such as recommended by le Groupe de travail (Quebec, 1986b), or extrabilling.

### Sale of Extra Services

Sales of some "extra services" at reasonable prices should be allowed to continue to develop, but not pushed. Revenues from parking lot fees, TV rentals, outside consulting, etc. could provide a few extra dollars for incidental "special projects". Such commercial activities involve some problems, however. If these sales involved basic patient care services, hospitals would place themselves in a conflict of interest situation, and patients would have grounds for fearing that their welfare was being compromised. Thus, new commercial ventures should not involve basic patient care services; for example, the sale of optional "fancy meals" should not be permitted. Moreover, there is also some danger that expanding commercial activities may divert staff attention from the primary mission of the hospital, patient care. Finally, provincial "ear-marking" of the funds for particular purposes is debatable because some hospitals' capacity to raise money from such sources may not correspond very well of their needs.

Increased Private Funding of Capital Projects

The central issue is who should decide what new projects should be done, not the method of financing the projects. Private financing should not become a way for hospitals to circumvent public investment policies[1]. The State must have final authority for investment plans, otherwise both efficiency and equity in access will be compromised.

Actually, it is a misnomer to view hospital borrowing--and even philanthropy to some extent--as "private financing". The State ultimately pays for a project whose capital costs are initially financed by borrowing, and at least part of the cost when financed by philanthropy. Thus, the financing of approved projects cannot really be "privatized".

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[1] The same comment would apply to other sources of private funding, such as extrabilling and the sale of extra services.

## Investor Ownership of Acute Care Hospitals

There is little evidence suggesting that changing the ownership of Quebec's hospitals--even just the small and medium sized ones as suggested by le Groupe de travail--would systematically improve their performance. In the United States investor-owned hospitals have traditionally made their profits by charging their patients higher prices than the nonprofit hospitals, not by producing services at lower cost. Of course, the situation in Quebec now is different from the situation in the U.S.. But there is no convincing reason that investor-owned hospitals in Quebec would be more efficient than non-profit hospitals.

Moreover, little is known about the negative side-effects of investor owned hospitals. The meager American evidence, however, suggests that the critics concerns are warranted. They have long been concerned that such hospitals make their profits by providing a lower quality of care and by "cream skimming"--by treating the inexpensive cases and shunting the costly ones elsewhere. These are important issues. If an effort were going to be made to stimulate the development of investor-owned hospitals, finding a way to avoid any such problems would have to be a central issue for the government. The best way to avoid them, however, is by avoiding investor-owned hospitals in the first place.

Of course, today there may be a few Quebec hospitals whose cost and patient care services would be improved by converting them into investor-owned hospitals. Their current management being weak, their efficiency and quality of care are poor. But an improvement in these hospitals' management alone could correct these problems; a change in their ownership as well would probably add little more to their solution.

## Subcontracting Management Functions

Subcontracting management functions can take a variety of forms, some leading to better hospital performance, some apparently not. There is anecdotal evidence suggesting that subcontracting the management of particular services can improve performance in some circumstances. On the other hand, there is little evidence in the literature that outside management of an entire hospital significantly improves efficiency. It is also important to realize that little is known about the impact of outside management on the quality of patient care services.

Moreover, there is good reason to be concerned that a policy of encouraging the subcontracting of management services would adversely affect the quality of existing hospital management. As the interest in investor-owned hospitals and outside managment suggests, there may be significant problems with the current management of Quebec hospitals. If so, the resolution of these problems should receive high priority from government. Bringing in a few outside managers would not solve them; it would only allow them to continue to fester. Government should concentrate on improving in-house managerial practices in order to deal with most current management problems. Outside managers should be used only to resolve particular problems, where specialized consultants were needed or where the needed skills were not available.

## Family Care

Family care, a substitute for in-patient hospital and nursing home services, also can take a variety of forms, and there is no reason that all would necessarily improve the performance of Quebec's health system. The effects of the three considered here are certainly not the same. The available evidence--one good quality study in each case--suggests that increased use of parent care for some hospitalized children and day surgery for some adult and child surgery is warranted. The cost of care would be lower, and the quality of care at least as good. But the available evidence, such as it is, does not support expansion of home care programs; indeed, it suggests a re-thinking of existing programs is warranted.

## Price-Competition

Price-competition would probably reduce government spending. But it is not at all clear that it would reduce total social spending; total health costs could be higher. Competition, moreover, would bring back some barriers to access that our present financing arrangements were designed to overcome. It would create a two tier health system, providing one standard of care to the non-poor and a lower standard to the poor. It would also, to some extent, bureaucratize access. Thus, it would certainly be premature now to recommend restructuring our health system in order to facilitate price-competition. The central question now is how much energy--if any--should even be focused on this idea in the coming years.

## HMOs

A key element in competitive structures is the HMO. Indeed, it may be the only active ingredient. Available evidence suggests that any cost reductions resulting from such structures would stem largely from the existence of HMOs rather than the operation of the price competition. Moreover, the adverse effects of competition on access seem to result primarily from price-competition itself, not necessarily from the existence of HMOs. This suggests that the idea of price-competition should be dropped and efforts concentrated on developing some HMO-like organizations here. The nature of the HMOs is important, however. Private HMOs are undesirable because they are socially inequitable, and they could prove inefficient as well.

Unfortunately, although HMOs have a variety of attractive features, it is doubtful that they would grow rapidly. Thus, it would be a mistake to view them as a solution for all our problems for the foreseeable future. Other steps should be taken to deal with current problems; the development of HMOs would only complement these steps.

## Other Forms of Privatization

There are, of course, other forms of privatization. As indicated in Chapter II, some are discussed in other reports prepared for this Commission. Others are not considered at all. In some cases--for example, the possibility of significant deregulation of the health care sector--this is unfortunate. But other forms have not been reviewed deliberately. For example, our entire system could be privatized by eliminating our universal, comprehensive public financing programs. There are a variety of ways of doing this. We could revert, for example, to the system which existed here prior to 1961 when public financing of hospital services was introduced, and which has continued to prevail in the U.S.. But there is little serious interest in scrapping the essential features of our present financing arrangements, so it would have been a waste of time to prepare a critique of proposals to do that. Moreover, nothing is lost by ignoring such proposals; a negative recommendation would have emerged from such a critique[2].

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[2] For a brief, reasonable appraisal of some of them, see Evans (1984), pp. 333-341.

## SOME OBSERVATIONS

The probable consequences of each privatization scheme for the efficiency and equity of Quebec's health system have been considered. It appears that many, though not all, would negatively effect the well-being of Quebec. Why? There does not seem to be a single, easily identifiable flaw common to them all. Instead, there seem to be a variety of problems with them. In several cases, the schemes do not make allowance for the special influence that physicians have on the functioning of the health system (e.g. users charges and price-competition). Many of the schemes would have adverse effects on equity, though the importance of this varies from scheme to scheme. It is a much bigger drawback with price-competition, for example, than with hospital sales of "extra services". In some cases the benefits simply do not warrant the costs for a variety of technical reasons (e.g. home care programs and investor-owned hosptials).

### Need for Scientifically Valid Evaluations

Throughout this review, the lack of empirical evidence has been noted. To be sure, there is some useful empirical research: considerable evidence now exists relating to some effects of user charges and some forms of family care. But for the other forms of privatization, much less empirical evidence bearing on key issues is available.

It is important to recognize that there is not now a mountain of reasonable evidence supporting the claims of many of the schemes' proponents and casting doubt upon the importance of the critics' concerns. This should certainly make one wary of wide diffusion in the near future of most privatization schemes.

As a general proposition, however, it is unreasonable to reject any proposed reform simply because the definitive empirical evidence does not exist demonstrating that the scheme does work as advertised. To do so would foster paralysis. That would be irresponsible. When "sufficient" information is available decisions must be made, and managers then must proceed with implementing the decisions and struggling with other problems. Time and energy are scarce. Thus, it has not been argued in this review that any particular privatization scheme should not be implemented simply because the definitive empirical evidence was not available.

It has been argued, instead, that many of these schemes are undesirable because the available evidence--theoretical as well as empirical--suggests that they would not enhance social welfare. As a result, rather than wait for definitive evidence for some of them, evidence which would probably prove negative anyway, it seems preferrable now to look at other solutions for current problems--solutions which seem more promising. For example, instead of spending a lot of time experimenting with outside managers, it seems preferrable to begin now to strengthen existing management practices. This is something that must be done, anyway, as explained below as well as in Chapter VI and VII.

Alas, the evaluations presented here may not prevent some of these schemes from actually being tried, however. Some people may disagree with the conclusions reached here. Others may believe that it is important to obtain the missing evidence.

OK. But any privatization schemes--as well as any new services--should only be introduced on an experimental basis. It is imperative that they be subject to a scientifically valid evaluation of their equity and efficiency effects before they are widely diffused.

Much has been said in recent years about the importance of proper "technology assessment" of medical technologies. It appears that the failure to assess properly new technologies in the past is now proving very costly for Quebec society. These concerns, however, are equally valid for ways of organizing the health system. Just as proponents (or critics) of seemingly attractive new machines, procedures and pills have sometimes been proved wrong by proper assessments, so too may proponents (or critics) of some seemingly attractive new forms of privatization be proved wrong.

## Lack of Information about "Private Consequences"

One of the most striking findings of this literature survey is the scarcity of evidence relating to the "private consequences" of privatization--its effects on the patients involved and their families[3]. Our health policy for the past 25 years has been directed at improving the welfare of these people, yet these are people for whom the effects of privatization would most likely be negative. Certainly the critics have long claimed that many forms of privatization would negatively effect these people. Thus, the private consequences should have been a central issue in research on the effects of privatization. A high priority should have been attached, for example, to answering questions such as the following ones: What is the impact of privatization on patients' emotional and physical health? What is the emotional, social, and economic impact on patients' families? What is the impact on people of different income classes?

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[3] Equally striking, most researchers as well as many reviewers of the research literature seem little concerned about this scarcity of evidence.

Of course there is some evidence; the issue has not been totally neglected. For example, as a result of the RAND Health Insurance Experiment, there is at last some evidence on the health effects of user charges[4]-- evidence suggesting that concern about the health consequences of user charges is warranted, and that researchers should not have neglected this issue so long. Moreover, as Evans and Robinson (1983) indicate, there has long been some evidence that parental care has positive health effects on the children. As well, Pineault et. al. (1985) have provided some evidence with respect to the health and private cost consequences of day surgery.

There is also considerable evidence relating to the effects of home care programs on patients' health. But in the major evaluations of home care during the past 10 years, little attention has been given to the consequences for family members or to the costs -- out-of-pocket or otherwise -- borne by the families. Moreover, there is very little evidence at all relating to the private consequences of investor-owned hospitals or outside management of hospitals. Finally, given past practices, it is a reasonable conjecture that research relating to the impact on quality and equity of the growing competition in the American health system will be very slow in coming.

There are probably a variety of reasons for this unfortunate situation, ranging from the difficulties involved in quantifying these private consequences to insufficient concern about them[5]. Whatever the reason, the focus of research has been on the utilization of services and on program costs for hospitals, governments and insurance companies.

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[4] It is interesting to note, however, that even though there existed a multitude of studies relating the utilization effects of user charges and essentially none relating to their health effects, the primary purpose of the RAND study was to estimate once more the utilization and cost consequences of user charges, not to estimate the health effects (Newhouse, 1974).

It is important to recognize that there is not now a mountain of reasonable evidence indicating that the private consequences are insignificant. Researchers have not shown that the critics were wrong. This situation, as already indicated, should certainly make one wary of most privatization schemes, at least until reasonable evidence about their "private consequences" becomes available.

More importantly, however, this situation raises a serious question regarding the desirability of implementing privatization projects, even if the research findings eventually are favorable. Will "private consequences" ever receive their proper emphasis in operational programs? Will narrow minded politicians and bureaucrats be satisfied with programs as long as they reduce government spending, whatever their "private consequences"? Suppose a well-designed research project implied that a particular form of privatization would not have significant negative private consequences, if certain resources were available to the people. Is there good reason to expect that cost-conscious government officials would make the necessary resources available if the program was actually implemented?

Moreover, if researchers have had difficulty measuring the private consequences, will government officials be able to develop effective administrative mechanisms to maintain proper quality of care? For example, it may be tempting to think that the introduction of investor-owned hospitals would not adversely affect the quality of care because quality would be monitored and maintained by a provincial agency. But would theory and practice coincide--would patients and their families actually be properly protected? How well could such an agency monitor quality of care and "cream-skimming" when researchers have had a difficult time finding ways to assess such effects in well-designed, well-funded research projects? What sort of resources and powers would such an agency have?

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[5] This situation cannot be attributed entirely to the obviously real problems of measuring the private consequences, however. For example, patients' out-of-pocket costs should not be too difficult to measure, but they have often been neglected.

## Impact of Privatization on Industrial Relations

Privatization would obviously have important implications for health workers, physicians to hospital orderies. One of the primary goals of most schemes is a reduction in hospital services, which means a reduction in hospital employment. There would also frequently be a reduction in physician services. How would the health workers be treated? It is very striking that in most discussions of privatization, little attention has been given to the implications of privatization for collective bargaining. But, as indicated, for example, by the tensions at Pointe-au-Pic, where the Manior Richelieu was recently privatized and the new owner has been trying to destroy the existing union, privatization can have very important implications for industrial relations.

One aspect of equity, as indicated in Chapter III is that health workers should be treated fairly. Would the integrity of their unions and federations be protected? Would their acquired bargaining rights be protected? Do existing procedures for dealing with redundant workers adequately protect workers' personal welfare?

The point is not that hospital workers--any more than physicians--should be able to veto socially desirable changes in the health system. Rather, the point is that careful attention must be given to the impact of changes on the workers involved when evaluating the social desirability of changes and when making the changes.

## RELEVANCE OF PRIVATIZATION

Up to this point, attention has been focused on whether the various privatization schemes would actually perform as advertised. But they should also be appraised in terms of their relevancy for current problems. If we were spending too much money for health services primarily because insufficient use was being made of parent care, for example, then obviously developing parent care, a form of privatization, would be very important. But if parent care did little to reduce the excessive spending, then privatization would not be very important. It appears, in fact, that the actual situation in Quebec is much closer to the latter situation than to the former[6].

### Continuing Importance of the State

With or without privatization, the State will continue to play a very important role in our health system in the foreseeable future. To illustrate this point, consider the determination of health spending, a central issue in current health policy debates. The State will certainly continue to shape health spending.

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[6] This is not to deny the usefulness of parent care. Rather, it is only to make clear that parent care, a socially beneficial form of privatization, is not the complete solution for all the ailments of Quebec's health system.

Privatization would not substantially reduce the State's role. With deterrent charges, the State would determine the amount of the charges, and it would continue to determine physicians' fees and hospitals' revenues much as it does now. With increased private financing via extra-billing or increased philanthropy and private borrowing, the State would still approve investment decisions. Any increased revenue from the sales of extra services would be too small to give the hospitals much financial independence. Similarly, even if hospitals were investor-owned or made extensive use of outside managers, the State would continue to determine the revenue received by such hospitals. Even with price-competition, the State would continue to shape health spending, as indicated in the previous chapter.

Suppose the privatization schemes actually worked as advertised. Their major impact would be on the efficiency with which available resources were used. For example, according to the advertising, deterrent charges would eliminate services of little or no value, and investor-owned hospitals and outside managers would increase hospital efficiency. HMOs--with or without price-competition--would do both of those things as well as adopt a more efficient mix of in-patient and ambulatory services and make more efficient use of physicians' time through the use of nurse practitioners.

But decisions about resource use, of course, do not mechanically determine decisions about resource availability. A reduction in waste, for example, does not mean that the State would make more resources available for health services. If user charges or an investor-owned hospital saved $100, the savings might be used to finance another Olympic stadium. Or, the hospital might think it needed $75 to refurbish its radiology department, but the State might allow it only $46[7]. Finally, even if "today's" spending were socially "optimal", a decision would still have to be made about the rates of increase in spending for higher fees, wages, and prices as well as for new services. This would require that the State make a series of judgments about what rates of increase were warranted.

Thus, the State's extensive involvement in the health system will continue, with or without privatization. As has been indicated in previous chapters, there are good reasons for this involvement, too. But this certainly does not mean there is no need to improve the performance of the State. This does not mean, for example, that its spending decisions are beyond reproach. Although a detailed review of the possibilities for improvement are beyond the scope of this assessment of privatization, it is useful to discuss some possibilities directly related to privatization, technology assessment and management structures and practices.

## Technology Assessment

In the current debate about the adequacy of current health spending, access to beneficial services is one of the central issues--if not the central issue. Physicians claim that more funding is needed in order to facilitate proper access to important new technologies, while government officials, influenced by some health planners, argue that additional money is not needed. They claim not only that there is adequate access to beneficial services, but also that many current services yield little significant benefit and should be eliminated. How can this important debate be resolved? Would privatization help?

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[7] The State's continued, independent influence on spending, whatever the effects of privatization, can be illustrated with several more examples. Even if the $100 savings were sufficient to resolve the hospital's underfunding, it might take two years to realize that saving. Rather than wait two years, it may be socially desirable to provide some additional funds now for the underfunded services. Moreover, these savings may require some initial investment in new facilities and services, which would need government approval and funding. Before parent care could be introduced, for example, some pediatric wards would have to be rebuilt.

In principle, the resolution of this debate seems straightforward: put more emphasis on technology assessment, as Evans (1984) and others have proposed. And, indeed, there is growing interest in it. The basic idea is simple. Technology assessment is viewed as a means of determining which services are beneficial for which people. If a reasonable assessment revealed that some people would benefit from a particular service, and the benefits were reasonable in the light of its costs, the State should be obliged to assure its availability to them. On the other hand, if the assessment revealed that the service did not benefit a particular group of people, or that the benefits were small relative to the costs, physicians should stop providing the service to them or stop demanding the ability to provide it to them.

Certainly greater use of technology assessment should improve public debates and decisions about health spending, though it is not problem free[8]. As a starting point, to return to an earlier theme, it seems quite reasonable that a minimal "operating rule" should be that new services not be introduced into the Quebec health system or changes made in its organization, without there simultaneously being a scientifically valid evaluation of them, unless there is scientifically valid evidence from elsewhere indicating that the services or changes were desirable.

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[8] The techniques of technology assessment are not perfect. For example, the long-standing difficulties of measuring and valuing some effects remain, and considerable time may be required to complete some analyses. Moreover, political processes will be involved when final decisions are made because the social desirability of services depends not only on their health effects, but also on social values. Finally, current regulatory practices with respect to new drugs serves as a reminder that technology assessment is not costless, either (Wardell and Lasagna, 1975). Despite the problems, however, much greater use of technology assessment seems warranted.

Although the health effects of medical technology, new and old, are a principle issue in the current debate about health spending, the privatization schemes that have been reviewed here would not resolve this issue. Certainly user charges, sales of extra services, privatizing finance, and family care would not resolve this problem. Perhaps with outside managers or HMOs better use would be made of available information about the effectiveness of various services, but it is not a foregone conclusion that this would necessarily happen[9]. Indeed, as already noted, HMOs have apparently adopted new technologies about as fast as other elements of the U.S. health system.

Moreover, investor-owned hospitals, outside managers or even HMOs would not generate the new information needed. The State must sponsor and encourage most technology assessment. Although the costs of an evaluation were warranted by the accumulated savings at all the Quebec hospitals, typically no single hospital--investor-owned or nonprofit--would sponsor it because the resulting savings for the hospital would not cover the high cost of the research.

Consequently, the relevancy of privatization as a solution for current health problems is related inversely to the need for technology assessment. If improving the efficiency of laundry services were the main thing needed to solve current funding problems, then we should be searching for ways to improve hospital management. Investor-owned hospitals and outside managment--privatization--would be possible solutions, each to be considered on its own merit. But, the debate among the medical profession, health planners and government is not centered on the efficiency of laundry services. This debate requires greater use of technology assessment, and privatization has little to contribute to that. Technology assessment is the responsibility of the State. Of course, some of this research could be privatized!

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[9] As argued below, if in-house and outside managers had the same incentives, their performance should be about the same. Moreover, however they might perform, HMOs' development would probably be too slow for them to have an appreciable effect on system performance for the foreseeable future.

Similarly, it is doubtful that privatization would resolve other pressing health system problems. For example, user charges would not dissolve existing barriers to services in rural areas or even provide a good framework for developing services for the aged. One must be fair: the serious proponents of many privatization schemes have never claimed that it was the solution for all problems. But, what is so striking is that even if all the privatization schemes reviewed here were introduced, many major problems would remain to be solved--problems ranging from inadequate public decision-making to poor health among various disadvantaged groups.

## ADAPTATION

Although the adoption of most privatization proposals reviewed here appears undesirable, the adaptation to the Quebec health system of some facets of these proposals is very desirable. The undesirable proposals typically involve the wrong incentives or lack sufficient constraints on providers' behavior. But this does not imply that all aspects of these proposals are necessarily undesirable. A key idea running through many of the privatization proposals is that our system would perform better if it were better managed. That is a reasonable position; the foregoing analysis of privatization is certainly not predicated on the idea that our system's management could not be improved. The question is not one of utility, but of modality.

The privatization proposals contain some interesting ideas relating to the structure of management and to aspects of management practices. Although this evaluation of privatization is not the place to develop these ideas in any detail, it is useful to describe some of them briefly.

## Structure of Management

An important element of the critique of current State involvement is that the State cannot provide the system with adequate "system-wide" management. The provincial government currently is the system manager, but for a variety of reasons--some good and some bad--it is not always disposed to pursue aggressively society's best interests. Although the goals of our health policy are not the same as an investor-owned firm in the private sector, that does not imply that the principles of good management in the private sector are inapplicable in the health sector.

Indeed, in situations where management in the health sector has been well structured, the performance record has been good. The performance of HMOs has long been widely acclaimed, as already indicated; that is why people are now looking for ways to stimulate the growth of HMOs. Given the current interest in introducing user charges and increasing the scope of the profit motive, it is important to note that neither has been the reason for the success of the HMOs. Little or no use is made of user charges and, at least until recently, almost all HMOs were non-profit organizations[10]. The success of HMOs is frequently attributed to their financial incentives: they are paid on a capitation basis and their physicians are not reimbursed via fee-for-service. Certainly their financial incentives may contribute to their success.

But there is another striking feature of HMOs which has received little comment and which appears equally important: powerful central (i.e. system-wide) management. HMOs like those of the Kaiser system involve not only a physicians' group practice and one or more hospitals, but also a central "management" with the authority, responsibility, incentive, means, and pre-occupation to make the HMO function efficiently. The emphasis placed on ambulatory services relative to hospital services is not something that automatically happens as a result of capitation, for example. It stems from deliberate management decisions[11]. Certainly the idea that the entrepreneur is a key actor in an organization should not startle either the theoretical economist or the practical businessman.

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[10] Given the interest in eliminating prospective budgeting for Quebec hospitals, it is also interesting that HMOs which operate their own hospitals use prospective budgetting. Special budgetary gimmicks for hospitals are not the reason for their success.

[11] There are several reasons for thinking that capitation is not the only active ingredient in an HMO. First, the HMO itself sets its capitation rate; it is not an exogenous variable, as so many commentators have implicitly assumed. The HMO can be viewed as setting its rate based on a mark-up over its expected per capita costs, while keeping an eye on its price relative to the prices of more conventional insurance. This means that the HMO has some control over its rate; the HMO really does not have fixed (per capita) revenues, except in the very short run (i.e. the period of time covered by the contracts to which it has agreed). Second, when capitation has been used in differently structured situations, the results have not always been very good. A good illustation is the apparent failure of the primary-care provider model (Moore, 1979; 1983 ). In this model individual primary-care physicians receive exogenously determined capitation payments for people who enroll with them, and then they are responsible for overseeing the provision of necessary health services to these people. They pay for necessary specialist and hospital services out of their capitation payment; they retain the residual and absorb the losses. Most have apparently ended-up absorbing losses, however, because they could not effectively control the services provided by the specialists.

The extent of management control also seems important. Management has more influence in an HMO like Kaiser than in an independent practice association, where the participating physicians are self-employed and reimbursed via fee-for-service by the association's administrative unit. But the Kaiser-type HMOs generally have lower per capita costs (Luft, 1978). Furthermore, HMOs that operate all elements of their plan themselves may have lower costs than HMOs which do not (Willems, 1976).

Note that one limitation of investor-owned hospitals or outside management of hospitals is that they deal only with improving the management of elements of the system. Even if they would favorably affect hospital efficiency, they would not improve overall "system" management. Analogously, good management of an HMO hospital is a necessary, but not sufficient condition for the overall success of the HMO.

How could Quebec develop more effective system-wide management, preferably something comparable to that of the HMOs? The unit to be managed should not encompass the entire province. Such a unit would be too big. HMOs do not have 6 million members. The largest U.S. HMO, Kaiser-Permanente (Northern California), had 1.7 million members in 1981. This suggests that Montreal could be a single unit. But all units would not have to be so big. Kaiser-Permanente (Oregon) had 250 thousand members in 1981, and the Group Health Co-operative of Puget Sound in Seattle, Washington, had 280 thousand (Newhouse et.al., 1985).

One obvious possible way to strengthen system management, then, would be to introduce a number of HMOs. Various mechanisms for doing this were sketched in Chapter IX. This might be worth trying. But, as indicated in Chapter IX, it may take a long time for HMOs to attract a significant fraction of the population.

A second possibility would be to dust-off and re-examine the old idea of regionalization. Regionalization certainly played a key role in the Castonguay Commission's vision of our health system. Moreover, we have had limited regional decision-making since the early 1970s. Does this experience suggest that full regionalization would not work in the coming years? What sort of changes should be made in our present structures to facilitate full regionalization? Rather than eliminate les Conseils régionaux de santé et de services sociaux (CRSSS), as le Groupe de travail has recommended, perhaps we should look for ways to give them overall responsibility for managing the health system in their respective regions.

## Management Practices

A variety of possible improvements in management practices at the institutional and the system levels are suggested by various types of privatization. Some examples are presented here.

Several possiblities have already been mentioned. As indicated in the review of outside management of hospitals, if there are problems with the current training and incentives of our hospital managers, a hospital system the size of Quebec's should be able to solve them without having to turn to outside managers (Chapter VII).

Perhaps Quebec hospitals could do more to exploit economies of scale. One of the alleged advantages of the hospital chains in the United States is that they are able to exploit economies of scale which are not available to single hospitals (Chapters VI and VII). Quebec has a chain of 241 hospitals, which is large by even American standards. The ability to obtain large price discounts as a result of bulk buying is a standard example of the way chains can save money. But there are other possibilities. Multi-hospital units could be formed in each region to take advantage of any economies of scale in the production of services. Shared services could include, for example, laundry services, computer services, laboratory services, and highly specialized treatment services. Perhaps, management of some hospitals could be consolidated, in whole or in part. The possible fusion of the Montreal General Hospital and the Royal Victoria Hospital is a very interesting development.

A third possibility that has also been discussed is the possibility of reducing provincial regulations confronting hospital managers. Because of time constraints, no attempt has been made to evaluate the existing voluminous regulations. Perhaps a working group should be formed immediately to review them, and then to recommend any changes that would lead to improved hospital performance. As a starting point, it might be useful to compare our regulations to those in other provinces.

The management of inputs, particularly physician manpower, appears to be another area where improved management practices are possible. Quebec has maintained a relatively "open door" policy with respect to physicians during the past 20 years. There have been some restrictions on the entry of foreign trained physicians into Quebec and some reduction in medical education in recent years. But, for all practical purposes, there have been relatively few restrictions on the numbers of new physicians or on their specialty and regional distribution. Consequently, our physician numbers per capita have grown rapidly (Contandriopolous and Fournier, 1986). In Quebec, we have a situation where physicians are reimbursed via fee for service, where there continues to be a substantial number of new medical school graduates each year, and where there are no significant barriers to entry. These are the conditions in which an excess supply of practicing physicians can easily develop. This has apparently happened in Quebec, and it is an important reason for our current problems (Soderstrom, 1985).

Quebec's approach to the management of physician manpower has been very different from the way manpower is managed by a typical firm in the private sector or by an HMO. Hydro-Quebec does not hire everyone who would like to be a lineman or an engineer; hiring decisions are based on its needs. HMOs, as well, make a judgment about the number and specialty of physicians needed, and then hire them; they do not allow any physician who wants to work for them to do so. As a result, HMOs have long used fewer physicians per capita than the conventional fee-for-service sector does (Stevens,1971; Hughes et.al.,1974; Steinwachs et.al.,1986). In 1978, for example, the HMOs in the United States used 30 percent fewer physicians per capita than where used in the conventional fee for service sector (Tarlov, 1986). This is an important source of the HMO's lower costs.

Incidently, here is a second reason for questioning the relevancy of privatization: it would not provide a solution for our apparent excess supply of physicians. Of the various privatization proposals, only the development of HMOs would provide a "private" mechanism to control physician numbers[12]. But it is doubtful that HMOs would grow very fast, so even this mechanism would be of limited usefulness, at least for the foreseeable future. Thus, even if all the privatization proposals reviewed here were adopted tomorrow and all worked as advertised, the government would have to do something to control physician numbers. For example, it might reduce medical school enrollments directly, or it might limit the number of new physicians who can practice in any particular region, such as British Columbia has recently done.

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[12] For example, investor-owned hospitals would not provide an effective control mechanism because more physicians may mean more business for them. User charges would not because physicians are probably able to alter the demand for their services in order to keep themselves busy.

Similarly, whatever is done about privatization, there is much that the government can do to shape the way available manpower is used, as indicated in Chapter IX. For example, public policy can shape where new physicians locate their practices. It can also shape the extent of manpower substitution. For example, suppose the use of nurse practitioners would still be beneficial. Before they could introduced in Quebec, their use by physicians would have to be legalized, and a mechanism put in place for remunerating them.

The final examples of improved management practices suggested by the privatization proposals relate to ways of providing decision makers with better information. Several have already been mentioned. It is frequently argued, for example, that outside management improves hospital performance, in part, by introducing better management information systems. But, if the management information systems in Quebec hospitals are deficient, outside management should not be necessary to remedy that problem. If it would significantly improve hospitals' performance, the implementation of a better system would seem to be a very good investment for Quebec now.

Perhaps consumers would benefit from better information, too. Certainly one of the attractive features of price-competition is that consumers, at least in theory, would have better information about the quality of care provided by providers. But, as noted in Chapter IX, even without competition, it would be very useful to make such information available.

The final example is not suggested directly by any of the privatization proposals reviewed here. It is suggested by the information essential for any firm in the private sector: any reasonably well-managed firm knows what it is producing. Hydro-Quebec would quickly flounder if it did not know how many kilowatts it was producing, and Bombardier would too if it did not know how many snowmobiles it was building and selling. But the managers of our health system know little about the health of the Quebec population--aside from when, where and why people die. The situation has improved a little in recent years because the Canada Health Survey of 1978 and 1979 has provided us with some health status information (Statistique Canada, 1981). Moreover, l'Enquête Santé Québec, which is now underway, will provide us with more. Quebec should have a periodic, household health survey. The technology assessment results would provide additional useful information about the output of the health system, complementing the health survey results.

## FINAL COMMENTS

Given the available evidence, privatization as a general strategy is not the major cure for the aches and pains of our health system. Two reasons have been offered for this conclusion. First, privatization is the wrong prescription. It appears that if the various proposals lumped together under the heading "privatization" were implemented, they would not resolve some major problems. These problems require that the State must purse more active policies, for example, with respect to technology assessment and manpower planning. In neither case would privatization *per se* contribute very much. Some forms of privatization are simply not designed to deal with these problems. Some forms might help, especially HMOs. But their development may take too long for them to be of much use. Major health problems, including those requiring much better technology assessment and manpower planning, should not be put on hold for at least 10 years until HMOs developed.

The second problem with privatization is that it frequently appears to be an ineffective, and in some cases a dangerous, prescription. Even for problems for which it is supposed to offer solutions, many forms of privatization are not desirable. As indicated at the beginning of this chapter, there are a few forms for which the effects would be positive. Greater use of parent care for hospitalized children and day surgery would improve the efficiency of Quebec's health system without adversely affecting equity. HMOs, if properly implemented, would, too. But, judging from available evidence, most forms probably would not resolve the problems for which they were intended. And some forms--particularly user charges and price-competition--would negatively effect efficiency and equity.

It is also important to recognize that there is not now a mountain of reasonable evidence indicating the effects of most forms of privatization, particularly their "private consequences". This situation should certainly make one wary of wide diffusion of most privatization schemes, at least until reasonable evidence becomes available.

Thus, privatization as a general strategy for reform is not attractive. But, as just indicated, there are some particular proposals--some forms of family care and HMOs--which are worth developing. Moreover, there are aspects of some privatization proposals that are worth trying to adapt to Quebec's health system. Examples relating to management structures and procedures were described earlier in this chapter. Although the adoption of most privatization schemes appears undesirable, the adaptation of some aspects of these schemes to the Quebec health system seems desirable.

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# Rapports de recherche et synthèses critiques publiés dans le cadre du programme de recherche de la Commission d'enquête sur les services de santé et les services sociaux.

## 1. Le rôle de l'Etat dans les services de santé et les services sociaux

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Le programme de recherche a constitué, avec la consultation générale et la consultation d'experts, l'une des trois sources d'information et l'un des principaux programmes d'activités de la Commission d'enquête sur les services de santé et les services sociaux.

Ce programme avait notamment pour objectifs de contribuer à la compréhension des problèmes actuels du système des services de santé et des services sociaux, de vérifier l'impact de diverses hypothèses de solutions et, à plus long terme, de stimuler la recherche dans ce domaine.

Afin de rendre compte de ce programme de recherche, la Commission a décidé, sur recommandation du comité scientifique, de publier une collection des synthèses critiques et des recherches. Le présent document s'inscrit dans le cadre de cette collection.